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STATE OF CALIFORNIA  
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING  
Friday, October 10, 1997  
8:30 A.M.  
1318 West Ninth Street  
Upland, California

REPORTED BY:  
Katherine Gale,  
CSR 9793  
Our File No. 39908

1           APPEARANCES:

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3           TASK FORCE MEMBERS:

4                   MR. ALAIN ENTHOVEN, PhD, Chairman

5                   DR. PHILIP ROMERO

6                   MS. ALICE SINGH

7                   MS. HATTIE SKUBIK

8                   DR. BERNARD ALPERT

9                   DR. RODNEY ARMSTEAD

10                  MS. REBECCA BOWNE

11                  MS. BARBARA DECKER

12                  MS. NANCY FARBER

13                  MS. JEANNE FINBERG

14                  HONORABLE MARTIN GALLEGOS

15                  DR. BRADLEY GILBERT

16                  MS. DIANE GRIFFITHS

17                  MR. TERRY HARTSHORN

18                  MR. MARK HIEPLER

19                  DR. MICHAEL KARPFF

20                  MR. PETER LEE

21                  DR. J.D. NORTHWAY

22                  MS. MARGARET O'SULLIVAN

23                  MR. ANTHONY RODGERS

24                  DR. HELEN RODRIGUEZ-TRIAS

25                  MS. ELLEN SEVERONI

26                  MR. BRUCE SPURLOCK

27                  MR. DAVID TIRAPELLE

28                  MR. RONALD WILLIAMS

1 MR. STEVEN ZATKIN  
2 MS. KIM BELSHE  
3 MS. MARJORIE BERTE  
4 MR. MICHAEL SHAPIRO  
5 MS. STEPHANIE KAUSS

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7 STANFORD STAFF:

8 MS. MARGARET LAWS

9 MS. SARA SINGER

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1 PROCEEDINGS

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3 CHAIRMAN ENTHOVEN: Good morning. I'd  
4 like to welcome you to the Managed Health Care  
5 Improvement Task Force. I particularly welcome the  
6 members and express my appreciation for your coming  
7 to this lovely junior prom facility.

8 We'll have a sock hop or whatever they  
9 call dances these days after lunch. So the meeting  
10 will now come to order.

11 I want to thank you very much for  
12 coming. I appreciate your coming to Ontario and  
13 giving up a day to do that is not easy for many of  
14 you.

15 I regret the scheduling of the meeting  
16 on the eve of Yom Kippur. I don't quite know how it  
17 happened, and it created problems for our shop too.  
18 So to accommodate people who need to leave early we  
19 plan to have a buffet here and you've got a notice in  
20 front of your -- on your table saying that we've  
21 arranged a luncheon buffet that's been preordered.  
22 And the buffet is \$5 per person which is a pretty  
23 good deal, and it will save us all the travel time of  
24 going to some restaurant. And it's \$5 per person,  
25 and we ask you to please pay Stephanie Kauss the  
26 executive assistant for the Task Force. Where is  
27 Stephanie?

28 MS. SINGH: She's right there.

1                   CHAIRMAN ENTHOVEN: Stephanie's back  
2   there, so if she comes around asking for \$5, kindly  
3   make your contribution.

4                   We have an extremely demanding  
5   schedule. This is, of course, created by the  
6   legislation and not by ourselves. But I trust from  
7   what many people said at the outset, boy, we have a  
8   really tough schedule to meet, so I'm sure we're  
9   going into this with our eyes open.

10                  We have responded to it by the process  
11   outlined in my letter of September 25. I'd like to  
12   review that and add some new thoughts about the  
13   process.

14                  We have sent you five papers for  
15   discussion today, and in addition to that, we will  
16   have discussion from two expert resource groups.

17                  We hope to have a lively and  
18   informative discussion of each one of the papers and  
19   of the ERG reports. But we will not vote on any  
20   papers today.

21                  Other than a vote on additional meeting  
22   dates, we will not take a vote today. And on the  
23   meeting dates let me make clear, there was some  
24   ambiguity in the papers that went out. Our intent  
25   was to authorize the possible use of three different  
26   dates; however, our intent is merely to ask you for  
27   one of those dates. So after we've had the formal  
28   vote approving it, then we'll come back and take a

1 straw pole and find out which date is least worst for  
2 members, and so our intent is to add one meeting to  
3 the schedule.

4                   We'll try to deal with that promptly so  
5 that everyone here has a chance to vote on that. One  
6 of the purposes of this discussion is to assist us;  
7 that is, to assist Phil, the staff and myself in  
8 understanding where is the majority sentiment in the  
9 Task Force to enable us to revise the paper  
10 appropriately to make it possible to put before you a  
11 paper that will receive a majority vote approval at  
12 the next meeting.

13                   So I will be taking informal straw  
14 votes as we go so that we can just get a sense if an  
15 issue comes up to say, "May I have a show of hands?  
16 How many are in favor or opposed?" in order to guide  
17 the staff in the revision of the paper. These votes  
18 are not binding and they're not Task Force decisions,  
19 they're informal guidance to the staff as to how to  
20 revise the paper.

21                   After this meeting we'll revise the  
22 paper to reflect the discussion and then get back to  
23 you in time for the next meeting at which we'll take  
24 a vote, first, on approval of the paper and, second,  
25 on each recommendation. What I propose to do is,  
26 whatever our recommendations, take them one at a time  
27 and have a vote on them.

28                   So please make no formal motions today.

1 We really must not bog down in the intricacies of  
2 Robert's Rules of Order if we want to get this work  
3 done. There will be opportunities for motions and  
4 friendly amendments and unfriendly amendments and all  
5 those wonderful things at a point in a future  
6 meeting.

7                   Today we do not have time to consider  
8 editorial comments. I'm sure many of you have  
9 editorial comments. Please write them on the paper  
10 and give the marked-up paper with your name on it to  
11 me, or if not today, in the next few days because  
12 part of our process is going to be to recycle these  
13 papers. I encourage people to resist the urge to  
14 completely rewrite the paper because we do have time  
15 limits for producing new papers, at the same time  
16 we'll be recycling these existing ones.

17                   We're here to discuss the major  
18 substantive issues that people want to bring to the  
19 Task Force, so each paper will be presented briefly  
20 and then we'll try to walk through it together. As  
21 these papers have gone to you, they're also going  
22 onto the web site so that they will be available for  
23 anyone who wants them. In fact, that's happened  
24 virtually simultaneously with the sending out of the  
25 papers and in the future will be simultaneous. We  
26 thought this would be the most practical way of  
27 getting the material out quickly so any interested  
28 groups or organizations will therefore be able to

1 comment on them as we go.

2                   Anyone who wishes to comment is free to  
3 do so. For any representatives of any of those  
4 entities that are here from the general public today  
5 and can hear me now let me say that brevity is an  
6 important part of being heard. A two- or three-page  
7 letter is much more likely to be read than a much  
8 longer one. I feel sure that all the Task Force  
9 members will be somewhat stressed for time and there  
10 will have to be prioritization on what is read and  
11 how carefully, so that would help a lot.

12                   What is before you does not preclude  
13 other additions or recommendations. If you want to  
14 submit additional recommendations at the next  
15 meeting, I encourage you to bring them in writing  
16 with enough copies to supply the Task Force or get to  
17 the Sacramento staff in time for them to make copies  
18 if you want to propose a new issue or new  
19 recommendation.

20                   The October 28th meeting will begin by  
21 voting on the revised papers discussed today, which  
22 will have been sent out to you in advance, then we'll  
23 go on to have an open discussion of the papers that  
24 will be voted on at the subsequent meeting and so on.  
25 This process is very condensed, but we're allowing  
26 time for due process. We will have Task Force debate  
27 and discussion on each issue.

28                   Because of the shortness of time, I ask

1 you to make your comments concise and not to repeat  
2 what others have said except to state your agreement  
3 or your disagreement.

4                   We have about one hour to discuss each  
5 paper or issue area today, that is allowing for a  
6 certain amount of time for breaks and for these  
7 opening formalities. Alice will keep the speakers  
8 list. That is a list in order that she sees hands  
9 raised of people who want to speak.

10                   I will -- I would like to just make my  
11 own role purely facilitating, but I realize that I  
12 will need help to explain the papers in some cases  
13 since I did direct their writing and I may ask brief  
14 questions for clarification if I sense that they're  
15 important unclarities.

16                   I've asked Peter Lee to help keep track  
17 of time and to advise us when we have 15 minutes to  
18 go on the discussion of each paper. So analogous to  
19 the 2-minute warning in football, we'll have a  
20 15-minute warning which will signal to people that  
21 we're going to have to accelerate our discussion to  
22 make the comments even more concise and proceed to  
23 wrapping up the discussion.

24                   At the end we'll ask the presenter to  
25 summarize what she or he thought they heard.

26                   I hope we'll reach agreement as quickly  
27 as possible on those that we do agree on in order to  
28 leave time for discussion of papers and

1 recommendations on which people disagree.

2                   Some of our papers today might be in  
3 that category.

4                   After the 15-minute warning, I will  
5 jump in and ask for a straw vote on whether the topic  
6 or point that's being discussed is one that the Task  
7 Force believes we should continue to be discussed.  
8 As Peter suggested, we will set a standard of five  
9 votes for 5 minutes. If I am uncertain as to whether  
10 there's support for continuing the discussion, I may  
11 suggest a straw vote, "Is there support for  
12 continuing discussion?" If there aren't five people  
13 wanting to continue on a particular topic, then we'll  
14 try to move to the next one. When it comes to  
15 overtime, we'll try to set a higher standard,  
16 possibly 10 votes, to continue. No more Mr. Nice  
17 Guy. I'm going to have to be fairly draconian here.  
18 If there is support for continued discussion on any  
19 issuing of a paper, we'll go into overtime, but I'll  
20 try to do it under strict time limits.

21                   If members want to raise other issues  
22 not now discussed in ERG reports, please let me know.  
23 If we get approval for extra meeting dates, we can  
24 schedule discussion. For new ideas it would be nice  
25 to circulate the idea and relevant information in  
26 advance so that no one is taken by surprise. I think  
27 that's one of the really very important principles  
28 that we want to work on is that no one is taken by

1 surprise. Also we're planning an opportunity for  
2 Task Force suggestions about issues overlooked on  
3 October 28.

4 The question has come up: Whose paper  
5 is the ERG report anyway? And I fear that our  
6 process may have bruised some feelings. And if so, I  
7 apologize for that.

8 Ultimately, these will be Task Force  
9 papers and not the papers of any individual authors.  
10 There's nothing to prevent the authors, of course,  
11 from publishing their own ideas in any appropriate  
12 setting. So I've had to step in and participate in  
13 the writing process in order to meet deadlines, in  
14 order to try to make the papers coherent and clear,  
15 to decide in which paper we will discuss a given  
16 issue, let's say such as the dispute resolution in  
17 several of the ERG reports, people had something to  
18 say about that. And in the interests of avoiding  
19 duplication and overlap I've made some judgment calls  
20 about in which paper we will consolidate something  
21 and to modify the papers in a direction that I think  
22 would be appropriate in order to increase the chances  
23 of getting majority approval. For example, I have  
24 persuaded some members to modify their  
25 recommendations in a way that would reduce the  
26 chances of polarizing the Task Force.

27 At this point, the papers have the  
28 ambiguous status of being joint products of the ERG

1 members of my staff and myself, and Phil will be more  
2 involved from now on. So it's sort of a committee  
3 product. And you all know that camel is a racehorse  
4 designed by the committee, so we do acknowledge  
5 that's a reality that we're dealing with.

6 We're counting on this discussion to  
7 help us understand the mind of the Task Force in  
8 order to be able to revise them to make them Task  
9 Force papers. Phil Romero and I will jointly take  
10 responsibility for the final results.

11 This procedure is at least as new and  
12 challenging to me as it is to any of you. It will  
13 surely cause stress, already has.

14 I hope and trust that you will treat  
15 the problems with tolerance and good humor. It's  
16 going to take a lot of goodwill to get us from here  
17 to there.

18 Now, I'll next ask Stephanie Kauss of  
19 the Task Force staff to call role. Stephanie?

20 MS. KAUSS: Just please indicate your  
21 attendance when I call your name. Alpert.

22 DR. ALPERT: Present.

23 MS. KAUSS: Armstead. Bowne.

24 MS. BOWNE: Here.

25 MS. KAUSS: Conom. Decker.

26 MS. DECKER: Here.

27 MS. KAUSS: Enthoven.

28 MR. ENTHOVEN: Here.

1 MS. KAUSS: Farber. Finberg.  
2 MS. FINBERG: Here.  
3 MS. KAUSS: Gallegos. Gilbert.  
4 DR. GILBERT: Present.  
5 MS. KAUSS: Griffiths.  
6 MS. GRIFFITHS: Here.  
7 MS. KAUSS: Hartshorn. Hauck.  
8 Hiepler. Karpf.  
9 DR. KARPf: Here.  
10 MS. KAUSS: Kerr. Lee.  
11 MR. LEE: Here.  
12 MS. KAUSS: Northway.  
13 DR. NORTHWAY: Here.  
14 MS. KAUSS: O'Sullivan.  
15 MS. O'SULLIVAN: Here.  
16 MS. KAUSS: Perez. Ramey. Rodgers.  
17 Rodriguez-Trias.  
18 DR. RODRIGUEZ-TRIAS: Here.  
19 MS. KAUSS: Severoni.  
20 MS. SEVERONI: Here.  
21 MS. KAUSS: Spurlock.  
22 MR. SPURLOCK: Here.  
23 MS. KAUSS: Tirapelle. Williams.  
24 MR. WILLIAMS: Here.  
25 MS. KAUSS: Zaremborg. Zarkin.  
26 MR. ZATKIN: Here.  
27 MS. KAUSS: Belshe.  
28 MS. BELSHE: Here.

1 MS. KAUSS: Werdegar. Shapiro.  
2 MR. SHAPIRO: Here.  
3 MS. KAUSS: Berte.  
4 MS. BERTE: Here.  
5 MS. KAUSS: Rosenthal. Quakenbush.  
6 That's it. Thank you.  
7 CHAIRMAN ENTHOVEN: We have just barely  
8 achieved a quorum. Thank you very much for making  
9 the effort to get here. Now I'd like to turn the  
10 meeting over to Phil Romero.  
11 DR. ROMERO: Thank you, Mr. Chairman.  
12 First, I would like to strongly endorse the opening  
13 remark the Chairman made with which I fully concur.  
14 Just one minor note, those of you who are interested  
15 in keeping up with the Task Force closely can, as the  
16 Chairman Enthoven mentioned, access the papers being  
17 discussed today and future papers as we locate them.  
18 They are on our web site. You can get our web site  
19 either directly or through the State's home page.  
20 The address for the State home page is [www.ca.gov](http://www.ca.gov).  
21 We are listed under -- in that home page are links to  
22 a variety of specific state agency sites. We are  
23 listed under as Alain announced properly the Managed  
24 Health Care Improvement Task Force.  
25 That's all I have.  
26 CHAIRMAN ENTHOVEN: Thanks very much,  
27 Phil.  
28 Now we'll proceed to new business. The

1 first item is discussion, an adoption of the  
2 amendment to the Task Force meeting schedule which is  
3 under tab III-A. In order to modify the meeting and  
4 hearing schedule I'll turn the meeting over to Alice  
5 Singh.

6 MS. SINGH: I think that the proposed  
7 amendments are pretty self-explanatory. Basically,  
8 we simply wanted the authority to call additional  
9 meetings, and as the Chairman indicated, it's the  
10 intention only to have one extra meeting, we're just  
11 giving you alternatives, three alternative dates.

12 DR. ROMERO: Thank you. I believe all  
13 three of the alternatives are dates that precede or  
14 follow meetings that are already scheduled. This is  
15 done simply to try to minimize your travel time. So  
16 in essence, it would involve staying overnight to  
17 participate the second day.

18 DR. NORTHWAY: That's not true of the  
19 December date.

20 DR. ROMERO: Except for the December  
21 date.

22 As a note, we do not yet have  
23 clarification about whether the legislature passed  
24 the bill allowing the reimbursement of Task Force  
25 members for travel expenses. So pending that  
26 clarification, I just want you to be aware that  
27 there's a possibility that if you -- if you vote to  
28 stay overnight, that it might be on your nickel and

1 not the State's.

2 CHAIRMAN ENTHOVEN: Do I hear a motion?

3 MR. LEE: Before moving to adopt, a  
4 couple of questions about the -- what's going to  
5 happen on the meetings. Is that appropriate to talk  
6 about now?

7 CHAIRMAN ENTHOVEN: Sure.

8 MR. LEE: One, just a clarification.  
9 As I understood the process we were going to try to  
10 follow is we wouldn't necessarily vote to adopt  
11 papers the first time they're presented. And so  
12 looking at the Order of Business for the 28th, in all  
13 likelihood we would not necessarily be voting to  
14 adopt the papers that would be presented there for  
15 the first time like expanding consumer choice,  
16 quality information, et cetera. And just clarifying  
17 on what's in the suggested Order of Business that  
18 what we would seek to adopt would be papers that we  
19 discuss today that would come back with revisions.

20 Is that correct?

21 CHAIRMAN. ENTHOVEN: Right.

22 MR. LEE: So the second thing besides  
23 adopting the time issue, from my understanding where  
24 we are at the public survey, and this is -- Hattie  
25 sent out a very helpful clarifying memo last week  
26 that noted preliminary data won't be available until  
27 early November.

28 Currently scheduled for the October

1 28th meeting is the discussion of the preliminary  
2 survey, and I think that that appears to be in  
3 conflict. And given that, I think we all want to  
4 have our recommendations informed by that survey, we  
5 need to consider what we move the presentation of the  
6 survey results to and consider how that might meet  
7 our need to revisit certain recommendations. So it's  
8 a -- that's just a --

9 CHAIRMAN ENTHOVEN: Right.

10 MR. LEE: -- specific topic concern.

11 CHAIRMAN ENTHOVEN: One thing is this  
12 schedule, let's say starting with my September 25th  
13 letter, is going to have to be under a process of  
14 some kind of constant rolling revision as we find  
15 which papers are able to be produced and which not.  
16 So I think your point is well taken about the survey.  
17 We certainly don't want to have discussion about that  
18 until people have had a chance to -- can we just  
19 clarify, Hattie, when will the survey be ready for  
20 members?

21 MS. SKUBIK: All of the data will be  
22 finished being collected at the end of this month.  
23 At that point we'll start getting preliminary data in  
24 and I will share it with Task Force members. We  
25 don't want to probably discuss it on the meeting on  
26 the 28th because -- I mean, it's possible that all  
27 the data will be collected by that point and they can  
28 share some preliminary data.

1 I think probably the best approach is  
2 to say that we'll share it as soon as we can. That  
3 would be very optimistic that we might have time one  
4 day that we can share it at that point, and if so,  
5 we'll do it at that point, but we may share it just  
6 in writing prior to a meeting. I think that would be  
7 appropriate.

8 CHAIRMAN ENTHOVEN: Thank you.

9 MS. BOWNE: If I could suggest then  
10 that it might be premature to schedule the additional  
11 meeting on the 29th because we would not have as much  
12 of the revisions in on the papers nor have the survey  
13 data. And while I'm certainly not a fan of a  
14 Saturday meeting, if we were to extend over to the  
15 Saturday, I would further suggest that we start  
16 earlier in the morning since we would have worked  
17 through Friday we might as well then start early  
18 Saturday and perhaps have the luxury of seeing the  
19 light Saturday afternoon.

20 CHAIRMAN ENTHOVEN: Right. I think  
21 that's a very good point. In fact, as I reflect on  
22 this I think probably among these dates the later the  
23 better because what's going to happen is some things  
24 are going to have to get rolled forward.

25 Peter.

26 MR. LEE: Could I -- some move that we  
27 schedule the 22nd and revisit the need for the 15th,  
28 I mean keep it on as a potential date, but hope not

1 to use it, but schedule now the 22nd of November --  
2 the November 22nd meeting and not do the October 29th  
3 for the reason that Rebecca noted and that gives us  
4 more time to have more background material prepared.

5 MS. SINGH: If I might make one more  
6 operational notice. Again what we're doing is we're  
7 just proposing that you adopt these dates. If any of  
8 you want to amend the October 29th date, that's fine.  
9 But if you adopt the schedule with the November 22nd  
10 meeting and December 15th, that gives us the option  
11 of having either a meeting on November 22nd or the  
12 15th. So you have to come back and amend this  
13 schedule again if you find the need for December 15  
14 if you don't adopt.

15 MR. LEE: Then I would move that we  
16 adopt it without the 29th, but that as a matter of  
17 our process separate from the public notices, et  
18 cetera, that we anticipate in all likelihood we'll  
19 actually do the 22nd and hopefully not do the 15th.  
20 So it's moot to adopt just the second to schedule.

21 CHAIRMAN ENTHOVEN: All right. Second?

22 DR. KARPFF: Second.

23 CHAIRMAN ENTHOVEN: Thank you. All in  
24 favor?

25 TASK FORCE MEMBERS: Aye.

26 CHAIRMAN ENTHOVEN: Anyone opposed?

27 MR. ZATKIN: Alain, I thought we were  
28 going to ask about availability. Is that not

1 relevant?

2 CHAIRMAN ENTHOVEN: We do have two  
3 dates now in which we could have a meeting. I think  
4 I agree with the idea that October 29th is not a good  
5 choice for the reasons expressed. So let's -- may I  
6 have a show of hands as to -- let's put it  
7 positively. Who would be available on the 22nd and  
8 then we'll do it for the 15th.

9 MR. LEE: Probably easier, who is not  
10 available.

11 CHAIRMAN ENTHOVEN: That's fine. Then  
12 let's start with that.

13 Who cannot come on the 22nd? Three  
14 cannot come.

15 How many cannot come on the 15th of  
16 December? Two can't come on the 15th of December.

17 MS. FINBERG: Maybe we should add  
18 another date. If this is the only time we can put  
19 dates in, would it make sense to put another date in?  
20 It may be a late one.

21 MR. LEE: Can I make a suggestion? I'm  
22 not sure why this wasn't suggested before, what about  
23 right before the meeting on the 12th, December 11?

24 CHAIRMAN ENTHOVEN: Or the 13th.

25 MR. LEE: December 11th is a Thursday.  
26 Can we maybe get a show of hands for who couldn't do  
27 that one?

28 CHAIRMAN ENTHOVEN: Who could not do

1 Thursday the 11th? One, two.

2 MS. DECKER: There's one over here.

3 CHAIRMAN ENTHOVEN: Oh, three cannot do

4 it. What about on the 13th? How many people could

5 not do Saturday, December 13th? Everybody could do

6 that?

7 MR. LEE: I mean, that's so close to

8 the 15th, why don't we just swap the 15th for the

9 13th? And not add another one. Rather than have

10 three days possible in a row.

11 CHAIRMAN ENTHOVEN: Okay. Thanks,

12 Peter, that's good. We'll just say that's a new

13 motion moved by Peter. And do I hear a second?

14 MS. BOWNE: Second.

15 CHAIRMAN ENTHOVEN: Okay. All in

16 favor?

17 TASK FORCE MEMBERS: Aye.

18 CHAIRMAN ENTHOVEN: Okay. Let's adopt

19 it. So where we are is everyone can come on the 13th

20 and all but three can come on the 22nd.

21 DR. ROMERO: Again, all but three of

22 those present.

23 CHAIRMAN ENTHOVEN: All right. Should

24 we make the decision now between those two?

25 MS. BOWNE: I thought that the sense of

26 Peter's motion was that we would hold both of those

27 dates with the idea of certainly using one, seeing

28 how we are progressing, then if need be, we could

1     also use the other.

2                     DR. ROMERO:   And also to suggest that  
3     at the end of the meeting of the 28th, we'll pick  
4     which of those two because we may have more members  
5     here who may have conflicts with one or the other,  
6     the 22nd or the 13th.

7                     CHAIRMAN ENTHOVEN:   We hold both dates,  
8     we see how we do, we decide on the 28th which one or  
9     possibly both.   Okay.   Thank you very much.

10                    Now, the next order of business.

11                    MS. O'SULLIVAN:   I don't know if this  
12     is the right place, but we need to have some  
13     discussion about how we're going to handle public  
14     testimony around the various papers.

15                    CHAIRMAN ENTHOVEN:   Well, we're working  
16     on a very tight schedule.   We are making the papers  
17     available.   We are obliged by the Open Meetings Act  
18     to have opportunities for the public to comment.  
19     Somehow we're just going to try to shoehorn all of it  
20     in, I think, asking commentators to comment briefly  
21     in the meetings.

22                    MS. O'SULLIVAN:   What I'm afraid of is  
23     that if we leave it to the end of each meeting, we're  
24     going to have so much important discussion amongst  
25     the Task Force that we're going to short shrift that  
26     section.   So my suggestion is that after each paper  
27     be allowed, whatever period of time we think is  
28     advisable for public input, move onto the next paper.

1                   CHAIRMAN ENTHOVEN:   Okay.   All right.  
2   We'll do it that way.

3                   MS. FINBERG:   Can I ask a question  
4   about the availability.   Are -- it was my  
5   understanding that these papers became available when  
6   a notice of the meeting and the agenda goes out so  
7   that these draft papers were available to the public  
8   when they were available to us.   But I was told by a  
9   reporter that he was told he couldn't have the  
10  papers, they weren't available.

11                   Is that right or not?

12                   MS. SINGH:   The papers were made  
13  available to the public when they were sent out to  
14  the Task Force members.   And so it may be that the  
15  reporter called before the papers were sent out to  
16  Task Force members.   But once they're mailed out to  
17  Task Force members, they become a public document and  
18  they are accessible to all individuals.   We've made  
19  them available on our web site as well to ease that  
20  availability to members.

21                   MS. FINBERG:   Can you give out that  
22  address because the one given out before is wrong.

23                   MS. SINGH:   Our home page address is  
24  extremely long.   So what I would suggest is that  
25  people access our web page by going onto the  
26  California Home Page which is in all lower cases  
27  www.ca.gov.   And there's an alphabetical listing of  
28  all the State agencies and just scroll down and under

1 "M" they'll see Managed Health Care Improvement Task  
2 Force. They'll just click on that, and it's pretty  
3 self-explanatory. If anybody has problems, they can  
4 call our office and we'll be happy to help them  
5 locate it on the web page.

6 MS. SINGH: Thank you.

7 MR. LEE: May I comment briefly on the  
8 outline of the report which I very much appreciated  
9 coming around. I recognize it's very much a work in  
10 progress. One of the things that I wrestle with is a  
11 lot of the issues do cut across different groups.  
12 And just to sort of affirm that this is a working  
13 outline that -- some of these topics may get merged  
14 or shifted around and this is sort of a starting  
15 point. The other suggestion is that  
16 under Background C which is "Observations of the  
17 Public Perceptions," I think it would be a wonderful  
18 thing, and I know staff hates hearing Task Force  
19 members suggest wonderful things staff might do, but  
20 to incorporate in that section a summary of the  
21 public testimony we received in some way, at the very  
22 least to acknowledge as part of this report that  
23 we've held "X" number of hearings that were  
24 specifically oriented to get public testimony, we  
25 received comments from 150 people. It's not  
26 representative necessarily of what is reality, but to  
27 do some effort to summarize who we've heard from, and  
28 not in a -- whether it's bullet or here are some of

1 the trends of issues. I think that would be a  
2 helpful piece that could also be shared at the same  
3 meeting we have shared with us the results of the  
4 public Task Force survey.

5 DR. ROMERO: Chairman, just a brief  
6 note.

7 Excellent suggestion. I've always  
8 viewed -- as I've seen it, we've been receiving  
9 public input from two basic sources. One are  
10 individual pieces of input through testimony and  
11 written products and the other is a more structured,  
12 more aggregate set of input through the survey. We  
13 need to have a section that covers both. So we'll be  
14 sure to produce it.

15 CHAIRMAN ENTHOVEN: Peter, I agree,  
16 that's an excellent idea. The testimony we get from  
17 the public, actually those reflect an important  
18 reality. I'm sure what you meant was it doesn't  
19 reflect a stratified random sample of the population  
20 at large which is why we need to do a survey as well  
21 as listen to the testimony of members of the public  
22 who have come to speak to us. But we are working on  
23 that.

24 MS. SEVERONI: Agree.

25 DR. RODRIGUEZ-TRIAS: I agree totally  
26 with that idea. Also I think we've received some  
27 very substantive material and particularly Tony, Amy  
28 and I who have been working on vulnerable populations

1 have received some very substantive materials from  
2 specific of constituency groups, particularly people  
3 with disabilities who are very well organized and  
4 form a very important part in consumer input into  
5 shaping health care. And I thought that we might  
6 look into including some of that as well. I don't  
7 know where it will fit in, it may be an appendix, in  
8 our case there may be some we can incorporate  
9 directly in the ERG paper.

10 CHAIRMAN ENTHOVEN: Right. Thank you.

11 MR. LEE: To follow up on that, I think  
12 it would be great to catalog what we've received and  
13 maybe about the part of the report that gets  
14 distributed will be so voluminous, but we've received  
15 expert testimony as well, it's the third thing that  
16 we've considered besides the public testimony so  
17 everyone knows as a matter of public record what  
18 we've considered to make our recommendation, so  
19 here's the full range of people we've heard from as  
20 well as the background material.

21 CHAIRMAN ENTHOVEN: Diane.

22 MS. GRIFFITHS: I have a general issue  
23 that I'd like to raise.

24 I was surprised when I got the papers  
25 -- I had expected that the papers --

26 CHAIRMAN ENTHOVEN: Diane, could you  
27 speak up.

28 MS. GRIFFITHS: Sure. I was surprised

1    when I received the papers to find that there were --  
2    some of them were authored by people who I gathered  
3    were staff members of yours or staff members of yours  
4    and I don't have a problem with that, but these  
5    resumes of the Task Force were circulated to us, and  
6    to the extent that people who are unknown to the Task  
7    Force are authoring these papers, many of them  
8    include statements, which is an ongoing problem to  
9    me, that factual statements without any supporting  
10   documentation, was footnoting of some stuff but other  
11   points are not footnoted. And I certainly appreciate  
12   getting the resumes of people who are authoring the  
13   portions of the report.

14                   CHAIRMAN ENTHOVEN: Sure. We'd be  
15   happy to supply that.

16                   Any other? All right. Then we'll  
17   proceed.

18                   The next order of business is to  
19   discuss the five draft papers and then the ERG  
20   reports. So we'll proceed along the lines that I  
21   indicated.

22                   Peter, we'll call it 9:20 now, we'll  
23   hope to get through the first paper in an hour.  
24   We'll begin with the discussion of the Health  
25   Industry Profile paper. Sara, are you going to --  
26   Margaret is going to present that.

27                   I'd like to introduce you. This is  
28   Margaret Laws who works for us. She has a degree in

1 public policy, went to Kennedy School, graduated  
2 Princeton University, experienced in health care  
3 policy work. Thank you, Margaret.

4 MS. LAWS: I want to try to keep the  
5 health industry profile piece as brief as possible.  
6 This is a background paper. This was a paper that  
7 was designed to satisfy the Task Force requirement  
8 that we present a background on the health insurance  
9 industry, how it's evolved and the state of health  
10 care in California today. What we've done in the  
11 paper is try to present a historical context of  
12 managed care, how there's been growth in managed  
13 care, give a brief overview of the regulatory system  
14 that governs insurance and managed care, define some  
15 of the major industry terms and structures, present  
16 some of the primary challenges and objectives of  
17 managed care as we think about improving managed  
18 care, and then discuss some current industry trends.

19 So it's a fairly tall order, and we are  
20 trying to keep it to as much of a background document  
21 as possible.

22 I'm just going to kind of run through  
23 the sections of the document very quickly, and then I  
24 think we can just move to discussion and suggestions  
25 from the Task Force members about improvements or  
26 changes.

27 We're basically running through a  
28 history of managed care, looking at the

1 pay-for-service system that proceeded managed care,  
2 the passage of the HMO Act in '73 and then move  
3 through the '80s cost pressures that forced a spread  
4 of managed care across the country, and then go into  
5 a description of major industry terms and structure,  
6 and then we basically define the industry as a  
7 four-tiered structure of purchasers, consumers, pairs  
8 and providers.

9                   We'll then go onto primary challenges  
10 and objectives where we highlight integrating a broad  
11 range of previous independent entities across a range  
12 of a sort of immigration laws as the primary  
13 challenge of an effective managed care system. We'll  
14 also look at the operating systems as a real  
15 challenge and one of the places where people have  
16 noted failings or shortcomings in managed care.

17                   Moving into industry trends. We look  
18 at trends in utilization. The managed care movement  
19 that's reduced hospital-bed days has impacted the  
20 physician supply and has forced a shift in the  
21 composition of the health care work force. And there  
22 we're looking at the increase and prevalence of use  
23 of APMS and physician's assistants, pure specialists  
24 in training programs, that's really addressed in the  
25 academic medical setting and the beginnings of some  
26 more integrated primary care programs.

27                   We also touch in this industry trend  
28 section on coverage on the managed care system

1 focusing on covering a broader range of issues in  
2 health care than fee-for-service previously had.

3 We also look at the fact of how many  
4 services are being carved and certainly treated not  
5 necessarily as part of the integrated system. And we  
6 note here that long-term care has also been an area  
7 that hasn't been integrated.

8 Looking at the industry structure, the  
9 expansion of HMOs through the '80s and then a  
10 significant consolidation of the industry, looking at  
11 mergers both at a horizontal level and vertical  
12 level.

13 Finally, we look into the area of tax  
14 status where we look very briefly at the shift from  
15 not-for-profit to for-profit status. And I think  
16 this is obviously an area where there could be a lot  
17 of discussion. What we tried to do was really just  
18 present there hasn't been definitive studies on  
19 quality of care differences between not-for-profit  
20 and for-profit organizations. The studies we've seen  
21 really focus on hospital-care populations and on very  
22 specific factors, but don't really address on a  
23 system-wide level tax status as a quality indicator.

24 So what we'll try to do here, as I  
25 said, is just give a very brief overview, introduce  
26 some of the terms and concepts that we're using  
27 throughout the other papers and highlight some of the  
28 issues that we're addressing in the Act. This is a

1 passing paper, there won't be recommendations.

2 CHAIRMAN ENTHOVEN: Do Task Force  
3 members have comments?

4 DR. ROMERO: I do. Just one brief  
5 clarifying comment picking up on something Margaret  
6 said in her introduction. Members that were called  
7 at the legislation establishing this Task Force  
8 required that we do basic report findings in about,  
9 if I recall, five categories. So there are five  
10 papers or sections that we're statutorily required to  
11 do.

12 The paper you just heard about is the  
13 first of those. As Margaret said, we had envisioned  
14 these as being primarily factual descriptions of the  
15 impact of the managed care on particular populations  
16 or measures of public policy objectives.

17 The recommendation will come in  
18 separate papers you'll be hearing about.

19 CHAIRMAN ENTHOVEN: Thanks, Phil. Yes,  
20 Peter.

21 MR. LEE: One of the things that we  
22 talked about trying to do is to move the discussion  
23 to ask if the people have suggestions or comments  
24 about section by section so executive summary first  
25 and then move on to another section rather than  
26 necessarily being across the board do people have  
27 comments.

28 CHAIRMAN ENTHOVEN: Let me suggest we

1 bypass the summary and get down to the material  
2 itself and then the summary will, of course, be  
3 revised to reflect that.

4 Dr. Gilbert, did you have your hand up?  
5 Oh, Alpert. Dr. Alpert, go ahead.

6 DR. ALPERT: This is just a question.  
7 On page 6 at the bottom it refers to "a more in-depth  
8 analysis can be found in the Task Force's 'Regulatory  
9 Environment Report.'"

10 Does that refer to material we've been  
11 given in the past where we've had a summary, or is  
12 that a forthcoming?

13 CHAIRMAN ENTHOVEN: That's a  
14 forthcoming paper. We had an oral presentation by  
15 Phil in Oakland.

16 DR. NORTHWAY: I just wondered as I  
17 went through this, maybe I missed it, there's nothing  
18 in this paper that talks about during the same time  
19 period any relationship to the number of people that  
20 are uninsured and I wonder if that should at least be  
21 put into this overall to say that this is one of the  
22 problem that's been emerging lately, whether it has  
23 to do with managed care or not, but there are  
24 obviously the increased number of uninsured when we  
25 have the lowest unemployment rate that this country's  
26 seen in a long time.

27 CHAIRMAN ENTHOVEN: So the suggestion  
28 is to add a trend. We have uninsured in 1994, but to

1 stretch that out as a trend. Okay.

2 MR. LEE: One of the things I noted  
3 earlier is that I had written, and I will give you  
4 comments about questions, about cites, support, but  
5 I'll try to restrain myself from noting. I've got  
6 two broad issues, one is I think there should be more  
7 discussion here with the world medical group from the  
8 industry. I think that's really missing here when I  
9 read through here about the growing importance of  
10 medical groups number, first.

11 And second, specific comment, page 4,  
12 the top of page 4 talks about the lack of oversight  
13 in the fee-for-service system. And one of the things  
14 that comes up in a number of papers is the fee for  
15 service compared to managed care, and I get somewhat  
16 nervous about some of those. If we aren't going to  
17 do a very full description about what really was  
18 there under fee for service, it somewhat becomes a  
19 straw man in some ways or a straw person.

20 And the -- in particular, I think that  
21 we need to acknowledge that under any system there  
22 are a number of quality-assurance mechanisms that  
23 always have been in place and need -- and are still  
24 in place such as peer-review processes, the medical  
25 review, the certification process of physicians,  
26 litigation, the access to the courts, which of course  
27 is very different for different people. But those  
28 are different elements of quality assurance that I

1 think we need to acknowledge.

2 CHAIRMAN ENTHOVEN: What page were you  
3 thinking?

4 MR. LEE: Top of page 4. It's noted  
5 that providers had -- it said, quote, unquote, "no  
6 oversight or quality-assurance mechanism." And  
7 there's a lot of debate about how effective  
8 quality-assurance mechanisms are today and have been  
9 in the past, but there have been quite a few, there  
10 were 10 years ago, there are now, and there are the  
11 different ones that we need to acknowledge.

12 CHAIRMAN ENTHOVEN: Okay.

13 MR. ZATKIN: Comment in terms of the  
14 regulatory overview, and I don't know whether it  
15 belongs here or it belongs in a subsequent paper.  
16 But I believe it's very important to communicate what  
17 the baseline is with respect to regulation of managed  
18 care. And I don't think -- I haven't seen that done.  
19 And as we move into other papers we talk about the  
20 role of the government and so on, I think we did get  
21 an overview from Commissioner Bishop early on who  
22 indicated that the degree of regulation is quite high  
23 and there are also federal -- federal regulations  
24 apply in some cases. And I think we ought to present  
25 a baseline, what is currently being regulated with  
26 respect to managed-care plans. So we show that we've  
27 considered that.

28 DR. ROMERO: Steve, just to respond.

1 There is a paper which the Task Force saw in very  
2 early form at the meeting in Oakland which pertained  
3 to my oral presentation which tried to describe who  
4 does what about the federal and state level providing  
5 a basic baseline as the background for the regulatory  
6 organization that we have. And we have a problem,  
7 it's a category problem. But we'll try to -- we can  
8 try to assure that its -- that its context is  
9 provided for this paper as well.

10 MR. ZATKIN: And I think it should be  
11 in a fair amount of detail because many of our  
12 recommendations address issues that presumably are  
13 not addressed in clear terms of what the baseline is.

14 CHAIRMAN ENTHOVEN: Your idea is on  
15 page 7 where we've talked about overview of  
16 California's --

17 MR. ZATKIN: I'm not insisting it be  
18 here. I think it needs to be a clear discussion of  
19 the degree of requirement that are applicable to  
20 managed-care plans somewhere in our report.

21 CHAIRMAN ENTHOVEN: Okay.

22 DR. RODRIGUEZ-TRIAS: I guess my  
23 remarks are along the same line but speaking to the  
24 national trends and some of the influences of what's  
25 happening in the national picture on the development  
26 of the structures in managed care in California. I'm  
27 not sure whether we're going to include some of that  
28 in the introduction which might be quite appropriate

1 and not necessarily stand in this particular section,  
2 but I'm referring to the move towards standardization  
3 of benefit packages, the impact of the HICFA  
4 regulation and financing on the shaping of it, that  
5 is things that are happening at another level but  
6 impact on the state the growing trend to legislate  
7 segments of the industry and so on. I don't know.  
8 Context.

9 CHAIRMAN ENTHOVEN: Okay. Dr. Alpert.

10 DR. ALPERT: Two things, with regard to  
11 Peter's comments before about the fee-for-service  
12 issues. I think it's fine as part of a background to  
13 say what it was and then what evolved. One thing  
14 that I would voice that I think we ought to try to  
15 avoid is the theme that recurs in discussions, and  
16 that's the comparison. We weren't asked, I believe,  
17 to compare what we have now versus what was. We were  
18 asked to analyze what we have and try to make that  
19 better if we decide that it needs to. And I don't  
20 want to confuse the issue about the comparison versus  
21 leaving it as part of the evolution.

22 My second comment has to do with what  
23 Dr. Northway brought up. Unless I'm wrong, I believe  
24 in the background one of the aims or hopefully side  
25 benefits of development of managed care as we know it  
26 now is going to be a dividend that was going to help  
27 pay for this problem of the uninsured, which of  
28 course was the thing that started with the Clinton

1 plan. And that's really not mentioned at all. And  
2 just in -- simply in terms of the background  
3 acknowledging as Dr. Northway said that that was a  
4 big problem, one of the hopes of the benefits of  
5 managed care was going to be to try to help that by  
6 virtue of the managed care dividend, if you will.

7 And then whether or not we want to  
8 analyze that is another issue.

9 CHAIRMAN ENTHOVEN: Let's -- I'm just  
10 trying to take that onboard here. I can understand  
11 adding a trend fact to the uninsured.

12 With respect to the dividend, it's a  
13 little -- well, we need to think about that, is there  
14 a dividend from controlling the cost.

15 DR. ALPERT: Not going in a specific  
16 direction, just in terms of background as to looking  
17 at the whole picture.

18 CHAIRMAN ENTHOVEN: Yeah. With respect  
19 to the first question you raised, in part to explain  
20 managed care and why it happened, we do have to talk  
21 about it, the explanation has to talk about what was  
22 unmanaged care or whatever we want to call -- which  
23 we usually refer to the traditional insured.

24 DR. ALPERT: I think that's  
25 appropriate.

26 MR. ZATKIN: I think that -- if I could  
27 comment on that point too. While the purpose of the  
28 Task Force is not to compare managed care to

1 fee-for-service, in evaluating the performance of  
2 managed care, one would need in part to consider  
3 relative to what? And so while we want to improve  
4 it, we may also need to look at the contribution, and  
5 those relate primarily to what was before.

6 CHAIRMAN ENTHOVEN: Yeah. I do think  
7 that's necessary. But is that clarified?

8 DR. ALPERT: I think that's fine. But  
9 I think we were asked to take a snapshot of what we  
10 have and see if we think anything is wrong with it,  
11 and then make recommendations as to how to fix it.  
12 And so I don't think things are -- I don't think the  
13 comparison is a bad thing to do, but I don't know  
14 that it addresses -- what I think they're looking  
15 for -- there's a ground swell of activity that's  
16 produced this, and they'll like help with it to avoid  
17 continued legislation.

18 CHAIRMAN ENTHOVEN: Right. Okay.  
19 Let's see, Dr. Gilbert.

20 MR. GILBERT: I had two specific  
21 suggestions to address Peter's points. The first one  
22 is your point, Peter, about physicians and their  
23 changing and the oversight. Under the  
24 fee-for-service area, page 3, I think if you put a  
25 paragraph in that gave a brief description of the  
26 typical or physician practice or set up in the days  
27 of whatever we're calling it, unmanaged care, fee for  
28 service, and I think if you do that and made brief

1 comments about oversights which are certainly  
2 hospital beds to oversight has always been present,  
3 pretty significant, I would pause that the individual  
4 practitioner oversight in those days was pretty  
5 minimal compared to the level of credentialing and  
6 so on that occurs now. I think if you could just do  
7 a paragraph or so outlining that and then do the same  
8 thing back near page 18 or 19 all you -- the only  
9 time you talk about IPAs, medical groups, is in the  
10 context of an HMO delivery system. And I think what  
11 you need to do is talk about what has happened to the  
12 physician practice in terms of development of  
13 integrated medical group and IPAs. That would then  
14 segue way into showing their importance and role in  
15 the managed care.

16 I think if you did those two things,  
17 you would have the context of how physician practices  
18 have changed and what that means in terms of  
19 oversight and managed care.

20 MS. SEVERONI: One of the elements I  
21 find missing in this paper which may go back to this  
22 fee-for-service versus managed-care discussion we're  
23 having here is I don't see it starting off with an  
24 overriding set of principles. I see it talking about  
25 techniques and structures. But there are some very  
26 specific principles that guide how managed care is  
27 structured for one moving from the care for an  
28 individual to looking at the care of a population.

1 And I think there are very specific principles and  
2 values that shift when one is looking at focusing in  
3 on the care of individuals all the time as opposed to  
4 looking at the care of populations. And those things  
5 shift whether you're a consumer or whether you're a  
6 provider and I think there are a variety of  
7 principles in there, that probably is where we ought  
8 to start this paper. Because even if we don't want  
9 to compare fee for service, managed care should be  
10 guided by a set of principles. And we should be  
11 making decisions about how structured practice and  
12 techniques based on those principles and I would like  
13 to see that outlined on this paper.

14 CHAIRMAN ENTHOVEN: I agree with the  
15 statement we ought to have systems governed by  
16 principles. If you're trying to describe what  
17 happened, one of those basic facts of the American  
18 experience with health care is the lack of agreement  
19 on principles. You know, I mean this kind of all  
20 happens when -- so I'm just having trouble thinking  
21 how would I write, you know, these were the agreed  
22 upon principles before, now these are the agreed upon  
23 principles, when, in fact, there's been just  
24 tremendous diversity of views as we've seen them when  
25 anybody's trying to perform neatly.

26 MS. SEVERONI: Sure. And I totally  
27 agree.

28 CHAIRMAN ENTHOVEN: This is kind of a

1 descriptive -- normally a paper, this is what it  
2 ought to be. But I do understand and we can do this  
3 to say one of the things about the fee-for-service  
4 system is the focus was on the right of physicians to  
5 practice in an unrestricted way and to deal one on  
6 one with their patients and the whole point of view  
7 is versus the managed care there is more of a focus  
8 on population based. We can bring those ideas in.

9 MS. SEVERONI: I would like to see this  
10 because I think that grounds on what we're doing and  
11 if indeed we don't have principles to guide this  
12 system, then maybe one of the recommendations we need  
13 to make is that overall we probably do need to have  
14 discussion to identify those principles and include  
15 the public in the dialogue and make sure that those  
16 principles guide the system.

17 CHAIRMAN ENTHOVEN: Okay. Diane  
18 Griffiths.

19 MS. GRIFFITHS: Some of my concerns  
20 have been expressed by other speakers, but I too  
21 believe that there's too much discussion of fee for  
22 service and criticizing it in detail, and in many  
23 places, not just in this paper, in ways that are not  
24 supported by some fairly specific cases that are not  
25 supported by footnoting. And I for one, absent some  
26 more evidence, subscribe to some of this persistence  
27 that we're all well aware that managed care is  
28 developed as a reaction to fee for service and

1     therefore it obviously needs to be discussed and in  
2     that historical context. But if we're going to go  
3     into a specific point in time and count criticisms of  
4     some of the specifics other than the cost of fee for  
5     service, which from my perspective is one of its most  
6     obvious throwbacks and the reason managed care  
7     developed, in fact, I couldn't subscribe to some of  
8     these detailed criticisms of fee for service without  
9     more evidence.

10                   CHAIRMAN ENTHOVEN: Okay. Peter Lee.

11                   MR. LEE: Very briefly. I think one of  
12     the things that Steve's comment brings to mind is  
13     there's not enough, in some ways, comparison within  
14     managed care. And that in terms of -- I mean, one  
15     thing in this paper, and it comes up less in others,  
16     is the fact that there's a broad spectrum of types of  
17     managed care organizations and within different  
18     structures PPOs's aren't really talked about much in  
19     here, and that's a -- one of the things we talked  
20     about in the first meeting is our charge is not the  
21     HMO Task Force or a particular type of HMO Task  
22     Force. Managed care, which I think we all agreed, is  
23     for the vast majority of Californians has a wide  
24     spectrum. The spectrum is acknowledged. But talking  
25     about those comparisons as being more important to me  
26     than the pure fee for service which is increasingly  
27     nonexistent.

28                   CHAIRMAN ENTHOVEN: Okay. Helen

1 Rodriguez-Trias.

2 DR. RODRIGUEZ-TRIAS: Maybe to put a  
3 final word on the fee for service as a straw person  
4 as was mentioned. I do think that when we ask the  
5 question as compared to why, the question ought to be  
6 as to compared to meeting the health-care needs of  
7 the population. And I think that's one that has been  
8 very limiting, I would say it's been a very limiting  
9 scenario in terms of how we've worked that we have  
10 been considering managed care and the population it  
11 serves strictly and not looking at the totality.

12 So I think that notion of making the  
13 framework the effect on insurance and the uninsured  
14 and then looking at managed care within itself as  
15 meeting the health needs of the population it serves  
16 rather than looking at what might have been or what  
17 was before.

18 CHAIRMAN ENTHOVEN: Okay. Thank you.  
19 Barbara Decker.

20 MS. DECKER: I think I'm echoing a  
21 little bit what's been said before. But I wanted to  
22 go a little bit further in that in our experience as  
23 an employer working with how health care is delivered  
24 today one of the key issues for us is how much is  
25 delegated to medical groups and IPAs from the medical  
26 plan structure. And several people have mentioned  
27 describing medical groups in greater detail, but I  
28 think this current drive to delegate and/or maybe the

1 medical groups are asking for the responsibility  
2 along with the money, that that's a dynamic that  
3 needs to be at least described and/or eliminated in  
4 some way because I think it's creating frustration  
5 from a consumer's point of view because they don't  
6 know who to go to to get help, et cetera.

7                   And along with that is the -- I think  
8 this was a very helpful chart showing the pacman  
9 aspect of the health plans becoming smaller and et  
10 cetera -- not smaller -- larger, fewer. But I wonder  
11 if it's worth taking the effort of showing a little  
12 bit of what's happened in the medical groups also  
13 because this is certainly having an impact at least  
14 in Southern California which I'm most familiar with.  
15 You know, every day I turn around and find out  
16 there's fewer groups and fewer entities to talk to.

17                   Now I wanted to clarify one thing. If  
18 we see things in here that we think perhaps they're  
19 not an important factor but we think they might be  
20 misstatements, are we just supposed to write on the  
21 document and give it back to the author? Is that the  
22 process?

23                   CHAIRMAN ENTHOVEN: That would be  
24 helpful. I'm just concerned about the availability  
25 of data on medical groups. Do you know --

26                   MS. DECKER: There are a couple of  
27 organizations, NITAC, the national, and the successor  
28 organization of AMGA.

1                   CHAIRMAN ENTHOVEN: Right. Thank you.  
2   Bruce.  
3                   DR. SPURLOCK: Thank you, Mr. Chairman.  
4                   I just want to agree with Brad  
5   Gilbert's idea about getting key information on  
6   medical which I think I would like to expand on that  
7   issue and echo some of Barbara's comments.  
8                   I think it would be very illustrative  
9   for this group and for this paper to talk about the  
10   different ways medical groups are managed. For  
11   example, there's the MSO model and the PTM modeling.  
12   Practice management is extremely different than  
13   contract management and fee-for-services operation.  
14   So I think it would be useful to include those types  
15   of differences. And I think it really illustrates as  
16   was pointed out in the article in the "New England  
17   Journal" that these structures are at least as  
18   important as the way managed care is played up, and  
19   actually there's probably 2,000 variations on the  
20   theme on those structures as well. I think pointing  
21   those things out would be illustrative. I think that  
22   there will be less information about who's using  
23   which model, even though we try to get some medical  
24   group information, who's using which model and those  
25   types of things changes from day to day in the  
26   medical group arena.  
27                   I also would like to make a second  
28   point, and it's a specific one, and it's -- my area

1 of expertise is in the health-delivery system, and it  
2 deals with the whole notion of excess capacity. And  
3 that was pointed out in the summary and then on page  
4 22 through 24 or 25. Somewhere in there it talks  
5 about hospital excess capacity and physicians supply.

6                   And the analyses that was pointed out  
7 in the paper are completely accurate, but they're  
8 incomplete. There are other analyses that do the  
9 same thing. I think it would be useful to have a  
10 balanced view point and discussion or debate on these  
11 two issues because I think there's been a lot of  
12 work. The Council on Graduate Medical Education is  
13 only one report about the number and types of  
14 physicians that should be out there. The Pugh Health  
15 Foundation published a report, the Institute of  
16 Medicine published a report and there's been several  
17 analyses should we have 50/50 benchmark for  
18 specialists and primary care. And I think that is an  
19 important thing to point out. There is some  
20 variation on that theme and there is this notion I  
21 think we ought to agree on, but how much and how  
22 severe it is needs to be pointed out in the paper  
23 just to provide a balanced viewpoint so that it's  
24 complete with the analyses that's out there.

25                   And the same on hospital bed supply.  
26 If you look at the analysis that's included in the  
27 footnote, while it's highly accurate, it's only one  
28 of the types of analyses that could be done to talk

1 about how much hospital supply we really need. And  
2 that's the question I ask people when I go out and  
3 work in the field, how much excess capacity do we  
4 really have? I think it's a huge issue that we need  
5 to deal with both in this panel and in the future.

6 DR. ROMERO: Follow-up question on the  
7 first of these two points about the medical group  
8 management models. Let's say we have one and one and  
9 a half. What would we do with that information, and  
10 I want to understand, you know, the -- I want to  
11 understand the context in which you think it's  
12 important so that we bear in mind when we do the  
13 write-up.

14 DR. SPURLOCK: Well, as you've outlined  
15 the different HMO or managed-care types of PPI, the  
16 POS, I think it's similar if you can identify the  
17 different physician-model types and I think you can  
18 also talk about the trend and the impact and where  
19 that may have a role in the way managed care is  
20 practiced in California.

21 For example, in an MSO you really only  
22 have contractual ways to control physician behavior.  
23 And in practiced management role there is a different  
24 level of control at the physician level on how a  
25 physician practices. And in fact, it may be more  
26 accessible to some people. The fact that they're not  
27 necessarily financial in the sense of a contract,  
28 they may control the behavior, but actually

1 utilization patterns, committee meetings that they  
2 have to attend, other things that may be more  
3 acceptable to some folks as far as how we actually  
4 control utilization and cost and delivery of care in  
5 California.

6 DR. ROMERO: Okay. Thank you.

7 CHAIRMAN ENTHOVEN: Jeanne Finberg.

8 MS. FINBERG: Yeah. I agree that we  
9 need more information about medical groups. And  
10 another area that I would like to see developed more  
11 is this section, of course, on consumers on page 20.  
12 This is an area where the change from fee for service  
13 to managed care is not well described, and I think  
14 it's very important to describe what the change is  
15 and to describe industry from the consumer point of  
16 view to address what some of the challenges and  
17 problems are and issues that have been documented as  
18 areas of concern to consumers. The cost issue seemed  
19 to be identified, but not some of the navigational  
20 issues and access issues that have been repeatedly  
21 identified.

22 And then finally on issues of  
23 accountability, and I think that it probably goes  
24 into this paper although it may be developed more in  
25 other papers. But from the consumer perspective how  
26 accountability is achieved and, you know, from the  
27 very small area all the way up to liability issue,  
28 that seems like it should be outlined in this paper

1 as the state of the industry.

2 CHAIRMAN ENTHOVEN: Okay. Thank you.

3 DR. ROMERO: Ron Williams.

4 MR. WILLIAMS: Yes. A few comments.

5 The first one I would like to make is very  
6 specifically needing to sort of describe the  
7 regulatory baselines as it relates to the  
8 accountability to members, the accountability to  
9 products, the accountability for accessibility for  
10 quality and for financial sovereignty and that's the  
11 accountability for various regulatory agencies and I  
12 think having a very descriptive baseline would be  
13 very helpful.

14 The second thing is that in the  
15 description of the delivery system, I found that  
16 there was some opportunity for improvement around the  
17 consumer features of the various delivery systems.

18 For example, I don't think it's well  
19 described how the consumer benefits from the  
20 tradeoffs that are made in moving from fee to service  
21 to the PPOs environment. For example, the member is  
22 getting the benefit of the negotiating discount  
23 that's taking place. Typically the health-care  
24 provider agrees to certain consumer features such as  
25 submission of all claims and paperwork. There also  
26 is typically the agreement to abide by that fee  
27 schedule and not bill the member additional costs. I  
28 think there's some very substantial consumer features

1 that are not accurately described.

2 I think another issue in terms of the  
3 issue of the uninsured is that this document in our  
4 world cannot solve the problem of the uninsured, but  
5 I believe we need to be mindful of the degree to  
6 which our actions either help increase or decrease  
7 the severity of the problems. So I think because we  
8 can't solve it, we shouldn't be implying the impact  
9 of our actions or the problems.

10 The other thing I think would be  
11 helpful is the data on consumers have historically  
12 participated in their cost of medical care over time.  
13 And I think if you go back, the studies you get are  
14 that consumers are paying a smaller percentage of  
15 medical expenditures over time partly depends when  
16 you start. If you start at '86 or '87, you pay more.  
17 If you're going back to 1960 or so, you pay less, and  
18 I think a descriptive data on that would give us a  
19 broader historical context.

20 The next comment is really around the  
21 medical groups and I think the answer to the question  
22 that Phil asked about what would we do with primer on  
23 this. One of those is make some comments on the role  
24 of medical groups as it relates to clinical quality  
25 management processes to the customer service features  
26 that medical groups and IPAs play for a lot of member  
27 service that they mentioned were responsible for.  
28 And also to the financial solvency and stability

1 questions.

2                   The final comment I will make is around  
3 consolidation. We've talked about information on the  
4 consolidation of medical group and IPAs. And I think  
5 there's also some interesting information on  
6 consolidation of the RAR Health Care Systems, groups  
7 like Cal HealthCare West and Southern System and  
8 other systems. But I think when you think about the  
9 system there is good descriptive information  
10 available on the mergers and affiliations that have  
11 gone on in the past three or four years here in  
12 California.

13                   CHAIRMAN ENTHOVEN: Okay. Thank you.  
14                   Martin Gallegos.

15                   HONORABLE GALLEGOS: Thank you,  
16 Mr. Chairman. I wanted to comment on a section in  
17 the report, and I wanted to take exception to some of  
18 the comments that were made in the report,  
19 specifically on pages 4 and 5 -- I'm sorry, 3 and 4  
20 under the fee-for-service section. There is what I  
21 believe to be a very strong negative slant to the  
22 comments in that particular area, particularly with  
23 regards to the role of the physicians in the  
24 fee-for-service system. It's a pretty blatant  
25 implication here in some of the statements that the  
26 motives of the doctors who are working in the  
27 fee-for-service system were predominantly motivated  
28 by economics and not by the practice of good-quality

1 medicine or health care.

2                   One line, specifically, that jumps out  
3 at me says, "Physicians predominantly operated solo  
4 practices and relied on referrals and personal  
5 relationships for new business."

6                   There's no addressing the issue  
7 that -- there are no comments to say that providers  
8 flourished in private practice under fee-for-service  
9 because they practiced good medicine, and that  
10 referrals were made to specialists because  
11 specialists treated those physician's patients with  
12 good-quality care.

13                  As one who's practiced under the  
14 fee-for-service system in the past, if I were to make  
15 a referral of one of my patients to a specialist and  
16 get a negative report, that's the last time I'll send  
17 a patient to that specialist. But I will look for  
18 specialists who are providing good care to my  
19 patients much as my patients, hopefully, would refer  
20 and continue to come to me because I'm practicing  
21 good-quality care. It's not because the more  
22 patients I see the more I can bill or the more  
23 services I can provide the more I can bill and the  
24 more I can get reimbursed. I'm not denying that that  
25 didn't exist, but if we're going to make a balanced  
26 presentation on fee-for-service, we shouldn't, I  
27 think, put this sort of negative perception and lead  
28 individuals to conclude that doctors were not

1 motivated under fee-for-service and couldn't flourish  
2 under fee-for-service if they didn't generate their  
3 own internal referrals as opposed to just practicing  
4 good medicine.

5                   And if possible, I don't know if we can  
6 make comments as specific as asking that that  
7 particular line which I read be struck from the  
8 report so that there isn't that perception painted to  
9 the general public that doctors in the  
10 fee-for-service system only operated -- were only  
11 able to flourish because of economic consensus.  
12 That's what I would like to request.

13                   CHAIRMAN ENTHOVEN: On top of page 4,  
14 "physicians predominantly operated solo practices."

15                   That's factual. Correct. "Rely on  
16 referrals and personal relationships for new  
17 business."

18                   HONORABLE GALLEGOS: Or if we could  
19 just add in there then another sentence to just  
20 balance that, say, something to the effect that, you  
21 know, we have to put something in there that says  
22 that, you know, to practice good-quality care they  
23 were also --

24                   CHAIRMAN ENTHOVEN: Yeah. Okay. I  
25 mean -- I don't understand how we can do that, yeah,  
26 all right.

27                   DR. SPURLOCK: I just want to make two  
28 clarifying points about something I think we need to

1 talk about, going back to the medical group issue and  
2 some of the comments about consolidation.

3 I think it's important for the report  
4 to reflect that the consolidation in the  
5 medical-group area is different from consolidation in  
6 a hospital and managed-care organization area and  
7 there has been significant trades and not necessarily  
8 consolidations as we typically think in a merger or  
9 acquisition.

10 In the Sacramento area Foundation  
11 Health Medical Group sold the group or transferred  
12 the group over to FPA. Med Partners backed out of  
13 San Jose because of growing IPAs net in the South Bay  
14 area.

15 So I think it's not necessarily been  
16 the same kind of consolidation. I think we need to  
17 highlight that in the paper when we talk about  
18 consolidation of medical groups.

19 The other thing I want to say about  
20 medical groups is in responding to something that  
21 Barbara said about, you know, actually asking for  
22 taking over some of the control for the financial and  
23 delivery standpoint, and I would say, just as a  
24 philosophical statement, that most medical groups I'm  
25 aware of have actually welcomed the notion of taking  
26 back the delivery control of their patients, both  
27 from a financial and delivery standpoint and that  
28 they like that because it gives them a greater level

1 of autonomy and actually more input on ways to care  
2 for patients. So I think it's been welcomed from  
3 those medical groups and I think we need to reflect  
4 that positive change from a physician standpoint in  
5 the discussion about these groups.

6 CHAIRMAN ENTHOVEN: OKay. Maryann  
7 O'Sullivan.

8 MS. O'SULLIVAN: A few things: I've  
9 got some comments that are a little bit like  
10 Dr. Gallegos' that have to do with how things are  
11 characterized on page 3. The primary challenge  
12 facing the systems have to do with integrating  
13 entities and, I mean, I think I've already challenged  
14 health-care financing and finding care for the  
15 uninsured.

16 So places like that maybe we can send  
17 comments in to you. Does that make sense?

18 Another one that I wanted to highlight  
19 today is on page 4 and on page 26 is a little  
20 discussion about mental-health benefits and it  
21 characterizes it as a very positive sunny thing  
22 that's happened in terms of mental health for people  
23 in managed care. I don't think that's the case. I  
24 think there are a lot of concerns about what kind of  
25 care people are getting and so on. So I object to  
26 that characterization and ask that --

27 CHAIRMAN ENTHOVEN: Where is that?

28 MS. O'SULLIVAN: On the top of page 4

1 and then on page 26.

2 At least, if there'd be a balanced  
3 discussion of what's happening with mental health --  
4 the benefits.

5 On page 26 under "covered services"  
6 where it says --

7 CHAIRMAN ENTHOVEN: "Coverage of mental  
8 health and substance abuse services has been  
9 increasing."

10 Well, are you saying that's not the  
11 case?

12 MS. O'SULLIVAN: If I read that I  
13 think, oh good, things are getting way better in  
14 terms of mental health, people in managed care, and I  
15 don't think that's safe to say across the board. I  
16 think there's a lot of problems with people with  
17 limited benefits and a lot of concerns people have  
18 about the way managed health care is being managed.

19 CHAIRMAN ENTHOVEN: The coverage  
20 contract under HMOs are much more comprehensive.

21 MS. O'SULLIVAN: It's an access  
22 question, coverage for one, but what sort of benefits  
23 are you getting? Under fee-for-service, people had a  
24 broader range of choices of mental health providers.  
25 I think that's very important, particularly in mental  
26 health.

27 MS. BELSHE: Is there any study on that  
28 subject? I mean, we're all wondering what is the

1 factual basis for the statement.

2 CHAIRMAN ENTHOVEN: This is about  
3 coverage now and I think, if you look at the typical  
4 HMO benefit package, part of the HMO law is to say  
5 there would be 20 visits for crisis intervention. I  
6 mean, one thing you can do is look at what the PERS  
7 contract says between the HMO and PPOs. And I think  
8 on the coverage side Maryann is raising questions  
9 about, well, you may be covered but have a hard time  
10 getting the provider you want.

11 MS. FINBERG: No, but it says coverage  
12 is increasing. It's not just managed-care versus  
13 fee-for-service. It's just coverage is increasing.  
14 It seems more like there's a documented trend.

15 CHAIRMAN ENTHOVEN: It says as people  
16 go from fee-for-service coverages in which the  
17 deductibles, co-payments and --

18 MS. FINBERG: I did not understand it  
19 that way.

20 MS. O'SULLIVAN: Also, fee-for-service  
21 it's unlimited visits to mental health providers and  
22 now we're limiting it to 20 or 24 visits per year.

23 MR. LEE: We're at the 15-minute  
24 warning mark so let's try to finish this discussion  
25 in 15 minutes.

26 MS. O'SULLIVAN: On the uninsured I do  
27 have a few comments. However, I don't think it was  
28 in this paper but subsequent papers described the

1 impact of managed care on uninsured people as being  
2 something positive, saying that because costs are  
3 down there's a belief that fewer people are uninsured  
4 than otherwise would have been and I don't see any  
5 evidence that says that's the case. And I think it's  
6 also important that we talk about the impact, we talk  
7 about what's the logical impact in terms of the  
8 willingness of providers to provide charity care as  
9 things are being ratcheted down over the buyers. So  
10 is that clear?

11 And then in the -- I agree with  
12 everything that's been said about comparing fee for  
13 service and managed-care and if anything  
14 characterizes our health-care system it's the lack of  
15 evidence to pretend we can compare it to  
16 fee-for-service.

17 And then finally, in this first paper  
18 I'd like to request that there be some discussion  
19 about Medi-Cal and what has been the trend for almost  
20 6 million people in the state with that system and a  
21 lot of folks are using managed care and what does  
22 that mean factually, what's going on there.

23 CHAIRMAN ENTHOVEN: Okay. Dr. Alpert.

24 DR. ALPERT: I guess it's good to start  
25 on this paper. It appears to me that we've  
26 identified it and I think Dr. Gallegos's comments  
27 really brought it up -- it's the concept of spin and  
28 actually this paper is great to look at because this

1 is as objective as it gets, this is the background of  
2 it. And I don't think that -- I mean, spin is here  
3 to stay and we have people on both sides and this is  
4 going to be to and fro and I actually think that's  
5 quite good.

6 I agree with a lot of things that Ron  
7 Williams said, but I was lunging for the microphone  
8 when he talked about to be sure to include the  
9 benefits that consumers get because of the negotiated  
10 discounted fees. I actually think that's fine to  
11 include because it tells them that there are benefits  
12 that they've received from negotiated discounted  
13 fees.

14 On the other hand, if you say that, you  
15 also are obligated to include that there may be some  
16 disadvantages because they may not be able to go to a  
17 certain doctor that they want to go to who has been  
18 the, you know, recognized as the expert but has not  
19 been allowed to get in the plan because it's a closed  
20 panel. It tells people what the state is and what  
21 the to and fro things are. And so I don't think the  
22 spin thing is bad as it comes out and I think we'll  
23 constantly have people on both sides to identify  
24 those thing and if we include both sides, I think  
25 that's fine then, that's informative.

26 MS. O'SULLIVAN: Doctor Enthoven, how  
27 are we going to arrange for public comment now? We  
28 said we would do it after each paper. Is that going

1 to be part of the last 15 minutes? Is that part of  
2 the last 15 minutes or does that come after?

3 CHAIRMAN ENTHOVEN: Well, I was hoping  
4 to give the Task Force one hour.

5 MS. O'SULLIVAN: And then we'll do it  
6 after?

7 MS. SINGH: Just as a clarification,  
8 remember that if members of the public want to  
9 address an issue that's on the agenda, they need to  
10 fill out a speakers card. We don't have any speaker  
11 cards filled out for this particular paper.

12 CHAIRMAN ENTHOVEN: Peter Lee.

13 MR. LEE: Just to follow on, I think it  
14 is a good paper to start on because it's so  
15 uncontroversial, but it's also good to try to set up  
16 our ground rules for how we're going to go through  
17 much harder topics and I'd like to make a couple  
18 comments and suggest a couple which is, one, when  
19 we're making comments, if we're specific, we know  
20 what page to turn to.

21 And so I'm going to have a specific one  
22 now on Page 21 at No. 1. And this is an example of  
23 what we're talking about, spin, which is at this  
24 integration between financial responsibility. It  
25 states: "In this stage of integration, provider  
26 incentives are aligned with patients' interests."  
27 This is one of the major disputes that I think is out  
28 there. And I raise it out loud here even though it's

1    what I might not have raised, I think, and said I'll  
2    submit this in writing and say not necessarily this  
3    is a matter of great dispute, show the other side in  
4    the write up and wait for that to come back.

5                   And so, as we to get through these  
6    discussions over the next meetings, we'll need to see  
7    how our comments get incorporated next time to get  
8    comfortable not to have to say them out loud. So  
9    that's an example there.

10                  DR. ROMERO: Actually, Peter, just to  
11    say as a point of procedure, even if you say them out  
12    loud, you increase the chances of them sticking if  
13    you also provide them in writing because we're  
14    fallible human beings, we forget things.

15                  MR. LEE: One thing to note with that  
16    is one of the great things about having a court  
17    reporter here is the notes of these discussions will  
18    be going to staff also to look at, but I've got this  
19    written and I've got it highlighted.

20                  Next is in terms of making specific  
21    recommendations and this comes -- Bruce noted it is  
22    very helpful if we, one, please cite why this is the  
23    case and I hope in the next draft a cite will come  
24    back or it will be gone or it will be qualified. If  
25    I think a contrary point should be mentioned and I  
26    know a good cite, just as Bruce noted three cites of  
27    studies, I think it would be very helpful to get back  
28    to staff and here's good studies on medical groups or

1 on whatever to make their life a little bit easier.

2 CHAIRMAN ENTHOVEN: Yeah. That would  
3 be very helpful.

4 MR. LEE: Then the other reason why I  
5 think it's important to be going through this is even  
6 these factual objective pieces aren't part of what is  
7 all of our report and that may be the one thing that  
8 gets grabbed upon as what we issue. So I think it's  
9 worth doing this discussion even though it's not the  
10 recommendation which is the hard part we're about to  
11 get to later today.

12 DR. RODRIGUEZ-TRIAS: I guess I would  
13 comment along the same lines as Peter about the  
14 specificity of it and also showing where there is  
15 controversy.

16 If I may say this: I was somewhat  
17 taken back by the section on challenges because I  
18 think the challenges on page 21, it's not to create  
19 cost-effective delivery but also cost-effective  
20 delivery that meets the needs, the health needs of  
21 the people and I think that sort of got lost  
22 somewhere, the issue of quality, the fit between, you  
23 know, what you do and why you do it, what you do and  
24 what should be happening as a result of what you do.

25 And I think the whole issue of  
26 improvement of health status has to be woven in  
27 somewhere as a major challenge within a cost-control  
28 or cost-limited framework.

1                   CHAIRMAN ENTHOVEN:   Okay.   Mark  
2   Hiepler.

3                   MR. HIEPLER:   One comment on page 7  
4   regarding ERISA and although it's a federal issue  
5   that preempts state accountability for HMOs, I think  
6   there's a misnomer at the very bottom that says:  
7   "Under federal Employment Retirement Income Security  
8   Act self-insured employer-sponsored plans are  
9   preempted from state regulation."

10                  I can help with some language on that  
11   because we deal with this day in and day out.   Really  
12   it's everyone is preempted unless three exceptions:  
13   State or federal employee, you buy your health care  
14   yourself, or you're a member of a church plan.   And  
15   that's one thing that most people have no idea, they  
16   think this is filled with accountability, filled with  
17   litigation, but in essence, because of this ERISA  
18   restriction, it should apply only to small  
19   self-insured plans, but it's been opened up so wide  
20   that now there's no accountability between -- for  
21   patients who are in ERISA plans to go after the HMO  
22   and then the accountability gets pushed on doctors,  
23   it gets pushed on medical groups, sometimes  
24   inappropriately so.   So I think if we could clarify  
25   how widespread ERISA is, and I know there's some  
26   discussion on whether the panel here should make a  
27   recommendation to the federal government regarding  
28   ERISA, I could help clarify.

1                   CHAIRMAN ENTHOVEN: That will be coming  
2 in a later paper.

3                   MR. HIEPLER: Okay. Okay. But it's  
4 key to understand how broad ERISA really is, and  
5 there's many people who are employed by the  
6 government here that don't have all of the problems  
7 that most us have.

8                   CHAIRMAN ENTHOVEN: You're saying it's  
9 beyond the scope of your employer.

10                  MR. HIEPLER: The reason for its  
11 institution was for small self-insured businesses,  
12 against the threats of litigation, to resolve  
13 disputes themselves. Now the industry has opened  
14 that up and it's a huge loophole where if you're  
15 making -- whatever you're making, if you're killed  
16 because you're denied of a procedure, all your estate  
17 can ever get is the cost of the procedure and not  
18 your potential earnings, not any other aspects of  
19 your livelihood and that's a preempted issue. No one  
20 really understands, yet it effects the accountability  
21 of how we hold HMOs accountable for their denials.

22                  CHAIRMAN ENTHOVEN: We do discuss that  
23 in a forthcoming paper. What I'm wondering is how  
24 much we want to go into it here.

25                  MR. HIEPLER: My point is just that it  
26 has to be accurate because the statement says  
27 "self-insured employer-sponsored plans are preempted"  
28 and that's much too narrow for what it really

1 preempts.

2 DR. ROMERO: If we simply replace  
3 "self-insured employer-sponsored plans" with some  
4 other, broader categorization that would handle it  
5 for this paper.

6 MR. HIEPLER: That's the point.

7 CHAIRMAN ENTHOVEN: Okay. Michael  
8 Shapiro.

9 MR. SHAPIRO: I had a comment on page  
10 29, discussion of for profit versus not for profit.

11 My concern was it's rather brief and I  
12 think misleading. I'm not sure I heard an anecdotal  
13 overview that quality is a wash. I'm not sure if by  
14 mutual report card such as the EBGH report card is,  
15 in fact, the case in California.

16 Secondly, I think there's a pejorative  
17 reference to basically tax restatus left more money  
18 for physicians. I don't believe non-profit plan  
19 physicians are paid any more than full profit, just  
20 the reverse. My understanding is --

21 CHAIRMAN ENTHOVEN: This is a reference  
22 to the olden days.

23 MR. SHAPIRO: Okay. But even if the  
24 olden days had our corporation of public benefits and  
25 social welfare foundation the for profit do not have  
26 the required share of community benefits and other  
27 things that, theoretically, the non profits' tax  
28 benefits were being dedicated to. So I'm not sure if

1 that's given proper reference in terms of why these  
2 organizations were given tax free status and the  
3 consequence of the movement to for-profit and  
4 whether, therefore, we're seeing much less public  
5 benefit activities associated with health plans,  
6 whether that's charity care or other community  
7 benefits, and I think you'll also have CMA and other  
8 reports indicating the degree to which revenue and  
9 profits are taken out of the health care system in  
10 the for profit entities in terms of shareholders and  
11 administrated by the money that is dedicated to  
12 health care and that, maybe, having an impact on the  
13 uninsured or, at least, more vulnerable population.  
14 So I think there may be an opportunity to make it a  
15 little bit more balanced and broader in this area for  
16 discussion.

17 CHAIRMAN ENTHOVEN: Okay. We'll take a  
18 look at that. Thank you. We have about 5 minutes to  
19 go. We have Ron Williams, Steve Zatzkin, Diane  
20 Griffiths and we hope to tie it up then. Okay. Ron.

21 MR. WILLIAMS: Just a few comments.  
22 One is, in this whole discussion about  
23 fee-for-service managed-care products, I think one of  
24 the things we should keep in mind is that many of the  
25 PPOs really are faced with service-oriented plans.  
26 One of the things that we believe is that there is  
27 important consumer choice and it should be maintained  
28 to provide close to fee-for-service as possible. And

1 it's really important for the consumers to understand  
2 the tradeoffs between the PPOs and HMO. And I think  
3 one of the things that always gets lost, and we might  
4 be sure to describe, is the difference between the  
5 deductible and co-payments. If the member doesn't  
6 face the deductible, they have immediately improved  
7 access to care and improved access to services. So I  
8 think that's an important issue.

9                   The second issue is I think there is  
10 good evidence on a number of uninsured groups that  
11 are coming in to the insurance market. I think HIPIC  
12 has some data to date that suggests about 22 percent  
13 of their groups are groups that have never had health  
14 insurance before and are coming into the market as a  
15 result of the affordability of health care. Our own  
16 data would suggest at least that number and maybe  
17 more. So I think there is data to demonstrate some  
18 level of payoff in terms of the cost benefit  
19 tradeoff.

20                   The final comment I would make is that  
21 there is an excellent study published recently in  
22 "Health Affairs," a whole issue on HMOs, what do they  
23 mean, how do they impact on quality or not impact on  
24 quality, and there was some research done recently on  
25 looking at the analysis of California HMOs and how  
26 the issue of profit and not for profit played into  
27 both current quality and changes in quality and  
28 that's information that I gladly make available to

1     you.

2                   CHAIRMAN ENTHOVEN:  Is the Task Force  
3     interested in a much more extensive discussion for  
4     profit versus not for profit?  I mean, we tried to  
5     make that fairly brief because we know there are  
6     strong views on both sides, but it's -- the evidence  
7     seems relatively inconclusive.

8                   How many people would like to see this  
9     spread out over two or three pages?  Do we want more  
10    discussion on that issue?

11                  MS. GRIFFITHS:  What are the  
12    alternatives?

13                  CHAIRMAN ENTHOVEN:  One page versus  
14    three pages.

15                  MS. GRIFFITHS:  But not this one page,  
16    a modified version of this one page?

17                  CHAIRMAN ENTHOVEN:  Yes.  I'm just  
18    trying to get a feeling for how much people want to  
19    see this issue.

20                  MR. ZATKIN:  The question now is what  
21    do you know?

22                  CHAIRMAN ENTHOVEN:  I don't think we  
23    know an awful lot.

24                  MS. FINBERG:  Then we can go to half a  
25    page.

26                  MR. ZATKIN:  If we know more, we should  
27    say more.  If we don't, we shouldn't.

28                  DR. ALPERT:  The more pages the more

1 potential for spin, and the less productivity and  
2 this is an area where you're going to have a lot.

3 CHAIRMAN ENTHOVEN: Okay. Thank you.

4 MR. ZATKIN: Figure 11 on page 20 is a  
5 description of the characteristics of different  
6 models and I frankly don't understand it. The last  
7 column, in particular, suggests "perceived M.D.  
8 freedom." I don't know if that's the freedom to  
9 practice or what. But if that's what it means,  
10 freedom to practice without interference, I would  
11 argue that the model is -- the characteristics are  
12 not properly denoted here.

13 CHAIRMAN ENTHOVEN: Okay. We'll rework  
14 this.

15 MR. ZATKIN: I think in group practice  
16 or, at least, in group practice, the type we have is  
17 quite a bit of freedom to practice without  
18 interference from an external party.

19 CHAIRMAN ENTHOVEN: Right. Okay.

20 Ms. Griffiths. I hope this will be the  
21 last speaker.

22 MS. GRIFFITHS: I just wanted to offer  
23 a suggestion for how to deal with some of these  
24 issues of controversy and I think a lot of the  
25 controversy over the issues of controversy that we're  
26 expressing today is the fact that many statements are  
27 made that seem to be -- in the form in which they're  
28 written, they're factual, they're stating facts,

1 where there's obviously dispute about them. And  
2 there's nothing wrong with them being in the report,  
3 but they should be identified as such and it's fairly  
4 easy to simply say, "The proponents of managed care  
5 believe," instead of stating as a matter of fact.  
6 For example, that mental health coverage is  
7 increasing under managed care, that way we've  
8 identified it as a statement and belief by the  
9 proponents of managed care rather than a matter of  
10 fact that we've received evidence of that.

11 CHAIRMAN ENTHOVEN: Or the proponents  
12 point to this. Yeah. Okay.

13 We have one member of the public -- oh,  
14 two who want to address this paper on the  
15 availability of mental health, Mr. Richard Van Horn,  
16 may I just request each of these people to kindly  
17 limit their remarks to three minutes.

18 Mr. Richard Van Horn.

19 MR. VAN HORN: I'm President of the  
20 California Coalition for Mental Health which  
21 represents the constituency of 30 plus statewide  
22 organizations that are members.

23 This is strictly on the history paper.  
24 I have other things to say later.

25 The history paper characterizes mental  
26 health care as improving and more available now than  
27 it had been in the past. That is indeed true in the  
28 public sector programs. The product of the Mental

1 Health Select Committee, under Assemblyman Bronson  
2 several years back and the Lieutenant Governor's Task  
3 Force on the seriously mentally ill in the late '80s,  
4 developed integrated tier models for people with  
5 seriously and disabling mental illness.

6                   There has been in recent years a trend,  
7 a great attention to systems of care, building  
8 integrated systems and developing quality-of-life  
9 outcomes which really show whether or not somebody  
10 got better as a result of the treatment intervention.

11                   In the private sector, unfortunately,  
12 in fact, it is our firm belief in the coalition --  
13 and I'm sure that within a few days I could back this  
14 with numerical data -- that there are more limits to  
15 visitations, there are higher co-pays required, and  
16 the thing that is most bedeviling to the public  
17 sector is there is a huge number now, particularly  
18 from HMOs, of unofficial referrals to the public  
19 system -- we can't treat your problem, go down the  
20 street to LA Child Guidance, they'll take care of  
21 you. But that person's Medi-Cal card isn't worth a  
22 plugged nickel at LA Child Guidance because it  
23 belongs to the HMO.

24                   This is creating this kind of cost  
25 shifting to the public sector and the non-profit  
26 agencies supported, in part, by all of your donations  
27 to United Way and whatever are frankly getting the  
28 short end of the stick in regards to this whole piece

1 of the system.

2 So I would request that the background  
3 paper be amended to indicate that there are some very  
4 different views on just how available this care is.  
5 And if you request, the coalition will produce for  
6 you the best documentation we can in very short  
7 order.

8 CHAIRMAN ENTHOVEN: We would really  
9 appreciate the documentation if you would send it to  
10 us.

11 DR. SPURLOCK: Thank you. You know I  
12 met with a physician who leads the California  
13 Psychiatry Association and he talked a lot about the  
14 delivery model is very, very different in mental  
15 health. And it might be worthwhile to look into some  
16 of those background papers because mental health  
17 delivery is very different from traditional delivery.  
18 So it might be worthwhile to expand some of that  
19 delivery system model discussion.

20 CHAIRMAN ENTHOVEN: Okay. Can you send  
21 us source materials on that?

22 DR. SPURLOCK: Real off the cuff, the  
23 HMO carves it off to a mental health plan, it doesn't  
24 have the complete geographic dispersion, it has three  
25 or four different networks that subcontract and  
26 there's usually four or five layers of contractual  
27 relationships to provide a broad geographic network  
28 to provide mental health benefits and that's very

1 different than what we see in other areas of the  
2 system.

3 CHAIRMAN ENTHOVEN: Okay. Thank you.  
4 The other -- then we have our next speaker, Verah  
5 Mthombeni, Loma Linda Child Adolescent Medical  
6 Clinic.

7 THE PUBLIC: Could we get a microphone  
8 for the speakers?

9 MS. SINGH: We're working on it.

10 CHAIRMAN ENTHOVEN: Would you state  
11 your name for the record, please.

12 MS. MTHOMBENI: Verah Mthombeni.

13 CHAIRMAN ENTHOVEN: Fine. Thank you.

14 MS. MTHOMBENI: Okay. I was very  
15 pleased to hear words like "accountability" mentioned  
16 by some speakers because I want to mention three  
17 points that I would really like the coalition to  
18 address with regards to accountability of the HMOs.

19 Now, I represent a private practice of  
20 a single physician and within the year that we've  
21 been under managed care we've had quite a few things  
22 that we experienced that I feel are very important  
23 that the coalition should be aware of.

24 The first one I would like you to be  
25 aware of is that the HMOs need to have qualified  
26 personnel making decisions in related fields.

27 In other words, the HMO should have  
28 physicians or personnel that govern or that make

1 decisions for appropriate -- for appropriate fields.

2 In other words, like a pediatrician  
3 shouldn't be monitored by another physician like an  
4 orthopedic physician. You know, if the HMO hires an  
5 official to be the one that decides whether a patient  
6 can be admitted in a hospital, that physician should  
7 have the knowledge of whatever field that patient  
8 belongs to.

9 The second point is IPAs have the power  
10 right now to manipulate the lists of patients that  
11 the doctors receive and there's no way of the doctors  
12 knowing whether the patients that they have been  
13 allocated -- that have been allocated to them -- are  
14 all they have and that they haven't removed any  
15 patients or they haven't -- I don't know how -- they  
16 have power to do that. And I don't want to get into  
17 lengthy explanation about that because it's happening  
18 right now.

19 The third point is that IPAs do not  
20 have specialists that are appropriate for all the  
21 fields. If I need to send a pediatric patient for  
22 circumcision, all they have is a urologist who only  
23 deals with adults. And I would have to send that  
24 pediatric patient to that urologist regardless of  
25 whether he's qualified or not.

26 So those are the three things I'd  
27 really like the coalition to look at.

28 CHAIRMAN ENTHOVEN: Thank you very

1 much. May I just offer to the general public a  
2 request and that is at this time after each paper we  
3 would like to take a discussion to specifics of that  
4 particular paper, then have a discussion about the  
5 issue in general afterwards later today.

6 All right. Thank you very much. Now  
7 we will move to the second paper, "The Impact of  
8 Managed Care on Quality, Access and Cost."

9 (Recess.)

10 CHAIRMAN ENTHOVEN: The members please  
11 take your seats. The meeting will please come to  
12 order.

13 Just two or three opening remarks.  
14 First of all, this paper will be presented by Sara  
15 Singer. Sara Singer is a graduate from Princeton  
16 University with an MBA from Stanford, has been doing  
17 health policy work for at least 10 or 12 years  
18 including a writer for "Health Week." She's been  
19 working with me for about seven years now and  
20 together we have published, I don't know, six or  
21 eight or so articles in the "Health Affairs" so I  
22 trust her views are well-known to readers of "Health  
23 Affairs."

24 A number of the comments that were made  
25 will kind of rattle through various of the other  
26 papers so I hope that we don't need to restate them  
27 again. We understand there are concerns about spin  
28 fee for service and so forth and we'll think about

1 that as we keep that in mind as we go through the  
2 other papers.

3 Next I would just like to call on Phil  
4 Romero for a second who would just like to raise the  
5 issue about the standard of care.

6 DR. ROMERO: Thank you, Al.

7 A theme that ran through a lot of  
8 comments on the first paper that I think will pervade  
9 certainly this next paper, probably several others,  
10 is this whole issue of evaluating managed care or  
11 more simply stated, finance about managed care's  
12 impact, in doing that in comparison to fee for  
13 service's impact in a particular area. In the next  
14 paper it's going to be on quality, access and costs.

15 I got very clearly, in the previous  
16 comments, the belief of a number of Task Force  
17 members that, as written, the previous paper seemed  
18 to characterize a strong aversion to fee-for-service  
19 that was, as a result, overly critical and, by  
20 implication, gave managed care more credit than it  
21 deserved. At least, that was my impression. Leaving  
22 the issue of spin and bias aside for a moment, which  
23 is something that we have to be careful about  
24 especially in truly factual and descriptive papers, I  
25 just want to take a minute and get the air of the  
26 following question and the question is, in essence:  
27 If we don't compare managed care to fee for service,  
28 what do we do? Let me put that question in context.

1                   As a policy analyst, I'm accustomed to  
2     evaluating a given alternative or given policy regime  
3     with reference to some reference standard. That  
4     standard can be a particular yardstick, like an  
5     objective measure of performance, or it can be in  
6     comparison to some other reference like case, like  
7     the status quo.

8                   I heard a lot of discussion along the  
9     lines that the evidence on fee-for-service is highly  
10    ambiguous and therefore comparisons can be  
11    misleading. But my question that I just want to ask,  
12    in essence, is: If we don't compare managed care to  
13    fee-for-service, what do we compare it to?

14                  In phrasing it that way, I'm revealing  
15    a bit of bias of my own which is that I don't think  
16    that comparing it to some undocumented or unempirical  
17    alternative strikes me as particularly useful either.  
18    I ask the question again: If we -- what do we  
19    compare managed care to if not the fee-for-service?  
20    Or to put it differently: Is there a way we can meet  
21    our statutory objectives without doing some sort of  
22    comparison in the first place?

23                  HONORABLE GALLEGOS: Thank you,  
24    Mr. Chairman. Phil, I think you hit the nail on the  
25    head when you said there aren't any standards to  
26    gauge managed care against and I believe that was  
27    part of your comments.

28                  I think that's the crux of the whole

1 argument here. That, I think, is what we need to  
2 work on and make recommendations for as a Task  
3 Force -- that we look at the managed-care system like  
4 Dr. Alpert said in a snap shot, which is my  
5 understanding of what we'll do. I'm not against  
6 having fee-for-service history given and maybe some  
7 background just so that individuals understand the  
8 old system, but this is the current system that 70  
9 percent of the insured population of California is  
10 under.

11                   And, you know, I think if we can make  
12 recommendations, that the governor is going to look  
13 at the Task Force for direction on that, to then as  
14 he said decide, you know, which of the legislation is  
15 good and which is bad and which should be signed and  
16 which should be vetoed, then I think we need to maybe  
17 state in the report that either there aren't any  
18 standards to measure managed care against or because  
19 there aren't standards to measure managed care  
20 against, we recommend that maybe these are some  
21 suggested standards, and then let the industry, you  
22 know, respond to that and say that's not true, you  
23 know, the advocates can say, well, you know, that's  
24 true.

25                   DR. ROMERO: Just to clarify, see if  
26 I'm understanding your point properly. There may be  
27 instances where we can set a particular standard of  
28 performance irrespective of fee for service or

1 anything else, and then compare managed care to that.  
2 And that's an answer to some of my questions in some  
3 areas.

4 CHAIRMAN ENTHOVEN: Bruce.

5 DR. SPURLOCK: Thank you,  
6 Mr. Chairman.

7 I have a slightly different spin on my  
8 perception and that perception is that we actually do  
9 have some measurements. We don't have great  
10 measurements, we don't have a lot of them but we do  
11 have some standards that are out there.

12 And let me give you one standard that  
13 we've talked about and that goes around is that  
14 Health Eagles 2,000 approach, the work we're doing on  
15 a federal basis. We can look at that from Helen's  
16 perspective by saying these are something we believe,  
17 irrespective of the system that delivers it.

18 Second of all, in the measurement of it  
19 we actually do have systems that we can compare that  
20 Helen Schauflier gave a lot of data on some of the  
21 health care issues of immunization, mammography, et  
22 cetera, et cetera. And I live in a world where  
23 benchmarks are reasonable, benchmarks are something  
24 to use as valuable tools. And to the extent that we  
25 have those benchmarks, we should use those, and we  
26 should say, "Okay, here's where we're meeting these  
27 benchmarks. Here's where we're not meeting those  
28 benchmarks." To the extent we exceed those

1 benchmarks, we then go on to say how we cannot be in  
2 need of Health Eagles 2,000, or some other perceived  
3 agreed-upon value which we say is worthwhile, and I  
4 think that's a goal that we can look at.

5                   And third of all, I think that there  
6 are some things that are happening and we are here  
7 to talk about quality and access in a second, but  
8 this is an area that I have a lot of interest in. As  
9 an example, Gaucher's disease doesn't have health  
10 management yet, it's just in its infancy, but it's a  
11 system that holds tremendous opportunity, it's an  
12 opportunity to actually improve the health status of  
13 people that didn't exist previously. And I think if  
14 we ignore the fact that different systems promote  
15 disease-management type models, I think we're really  
16 doing a disservice to what we're trying to accomplish  
17 here which is saying, "Here are the structures and  
18 incentives and paradigms that we work under that  
19 create these kind of structures that are beneficial.  
20 Here are the ones that we are falling short on and  
21 here is what we need to fix." And we can be abstract  
22 if we want, we can also be concrete and use concrete  
23 examples.

24                   CHAIRMAN ENTHOVEN: Steven.

25                   MR. ZATKIN: This is a discussion I  
26 wish we had earlier, but I'm glad we're having it now  
27 because it -- when you evaluate something you have to  
28 evaluate it in terms of some standard and I agree

1 that we do have some standards. There are numerous  
2 standards developed by NCQA and EDIS. When fee for  
3 service was predominate and we didn't have the same  
4 standard, so it's hard to compare. We just don't  
5 know. There are some items that are indicated in  
6 this paper. But in a general sense, I think we need  
7 to be cognizant of the fact that we're dealing with  
8 the question of whether -- how much -- managed care  
9 can improve within a context. And the context is the  
10 ability of the people of the State of California to  
11 provide a certain level of their resources to health  
12 care. What occurred under fee for service was  
13 increases in health care that were roughly double the  
14 rate of inflation over a pretty good period of time,  
15 and managed care was, at least in its newer forms, in  
16 part, a reaction to that. So if we're going to  
17 indicate how well managed care is doing and how  
18 managed care can improve, we have to consider, I  
19 believe, that overall context of the available  
20 resources for health care. Now no one knows exactly  
21 what that number should be and we may have some  
22 disagreement about it. But we do know that if we go  
23 back to pure free choice and there are no  
24 constraints, we'll go beyond where we need to be. So  
25 I hope that as we discuss improvement and as we  
26 discuss goals, we could, with an infinite amount of  
27 resources, reach most of the goals we're talking  
28 about better than we can with a finite set of

1 resource and I just want to put that notion out.

2 CHAIRMAN ENTHOVEN: Okay. J.D.

3 DR. NORTHWAY: I'd just like to follow  
4 up on that. I think the tone of the comparison  
5 between now and then is that the providers, whoever  
6 they were, were just ripping the system off. As a  
7 provider, not only as a physician but as a hospital  
8 administrator, I'm offended by that -- that, in fact,  
9 it was an uncontrolled system. There were no  
10 standards or very few. And now what we're comparing  
11 is a managed system versus, to a certain extent, a  
12 relatively unmanaged system. And obviously, as we  
13 begin to manage with a more critical look at what  
14 went on, hopefully, and what it has gotten to, the  
15 cost of health care is starting to come under  
16 control. But to pick on the providers, for instance  
17 they're the ones that rip the system off and then  
18 this knowingly, I think is really an injustice and  
19 offends me greatly as a provider.

20 CHAIRMAN ENTHOVEN: We'll be very  
21 careful and watch that and make sure that's not  
22 there.

23 J.D., one problem is it's one thing to  
24 say there are incentives for overuse which is a  
25 different thing from saying they're doing overuses,  
26 and I think there's widespread agreement that that's  
27 where the incentives were in fee for service.

28 DR. NORTHWAY: I think that incentives

1 was no one was telling you not to do something. You  
2 did things because, in fact, most of us -- not  
3 everybody, certain people ripped off the system --  
4 did things for the patient that they thought were in  
5 the patient's best interest. And we were taught  
6 almost, and I'm a graduate of your university, that  
7 economics was not something that we're supposed to  
8 think about in terms of taking care of patients.  
9 That turned out to be wrong because the economics got  
10 way out of hand and it turned out to be saying an  
11 unbridled system. But I think we really, by and  
12 large, did things that we thought would benefit the  
13 patient's health.

14 CHAIRMAN ENTHOVEN: I'll make sure that  
15 we go through from the point of view and tone not to  
16 have that kind of implication.

17 DR. RODRIGUEZ-TRIAS: You know, I was  
18 wondering if it would be helpful to have a -- insert  
19 a bit of chronology into the discussion of fee for  
20 service as well. I mean, I think there were two  
21 things about stages of development and changes in the  
22 organization of health care systems, you know,  
23 throughout, say, the 20 years preceding 1990, 1979 or  
24 whatever period we decide to do it, and just to have  
25 little bullets on the chronology because it makes it  
26 sound as if it was a totally homogenous thing and I  
27 think it's a little bit ahistorical.

28 But the second is I think that question

1 of variance and some of what Bruce said this morning  
2 about the internal quality controls that have been  
3 near and dear to the heart of providers for a long  
4 time. I mean, those of us who practice in academic  
5 institutions know that there was a lot of review of  
6 what we did all the time. Those of us who, even  
7 though the financing was essentially fee for service,  
8 but were serving in generally-funded programs had  
9 very high standards of performance in pediatric care  
10 that we had to abide by, like 95 percent immunization  
11 rate for under two year olds, so there are a great  
12 deal of -- great deal of heterogeneity there that I  
13 think is not acknowledged.

14 CHAIRMAN ENTHOVEN: Okay. Ron. I  
15 think that I'd like to get on with the paper.

16 MR. WILLIAMS: Just a few quick  
17 comments. I think one of the challenges that we face  
18 is that we are focusing on managed care and  
19 implicitly that reflects both on HMO and also PPOs  
20 and each of those members has a choice to go into  
21 fee-for-service arena and see any physician that they  
22 choose. So, to some degree, as we talk about managed  
23 care, we're also talking about fee-for-service. I  
24 think it's important that we do so in a level way.  
25 Our own experience has been very good. In our  
26 experience we think that physicians want to provide  
27 quality care regardless of whether it's fee for  
28 service or whether it's capitation. I think these

1 systems evolved. I think we see lots of physicians  
2 who practice in multiple settings, who are in a PPO's  
3 fee-for-service and also participate in HMO settings  
4 as well.

5                   So I think it's a comparison we can't  
6 avoid. I think it's a matter of how we characterize  
7 and do comparisons when we recognize it's an  
8 evolutionary system and that it will be with us for  
9 some time because there are consumers who prefer that  
10 form of health care delivery and physicians and other  
11 health care professions who prefer to practice under  
12 those kinds of settings.

13                   CHAIRMAN ENTHOVEN: Thank you very  
14 much, Ron. Okay. Now just coming up to 11:00, time  
15 keeper.

16                   MR. LEE: Yes.

17                   CHAIRMAN ENTHOVEN: And Sara Singer  
18 will present the --

19                   MS. SINGER: I should say this paper  
20 was originated by another person on our staff who is  
21 no longer at our office. It was also circulated to  
22 four Task Force members, two of which reviewed it and  
23 returned comments which have been incorporated. It's  
24 also one of the papers that is part of our  
25 legislatively required background information.

26                   I'm going to try and summarize the  
27 conclusions that we draw in the papers from the  
28 information.

1                   Starting with quality. Conclusions of  
2 literature review done by Miller and Luft, both of  
3 whom spoke to our Task Force, are that there are an  
4 equal number of positive and negative quality results  
5 for HMOs when compared to fee-for-service plans in  
6 the literature, that HMOs produced better, the same,  
7 or worse quality than managed care delivery and it's  
8 very dependent, highly dependent, on the organization  
9 and the disease.

10                   Trends generally characterized as  
11 positive in managed care, but certainly not  
12 universal, are quality measurement, improvement,  
13 publishing outcomes and report cards, coordination of  
14 care, focus on early diagnosis, prevention and health  
15 promotion, production and treatment variations,  
16 concentration of volume-sensitive procedures in  
17 high-volume centers and disease management for  
18 chronic patients.

19                   Also some questionable areas that came  
20 up in the literature review:

21                   Some studies indicate that there are  
22 worse outcomes for those who are both chronically ill  
23 and who are poor or elderly. Also: Concerns around  
24 shorter length of stay which may have an impact on  
25 quality; for example, on maternity stays.

26                   In the area of mental health, concerns  
27 both about the ability to detect mental illness by  
28 non-specialist primary care providers and also around

1 treatment and also the disruption of the  
2 doctor-patient relationship.

3                   With regard to access, the access story  
4 we found was one of tradeoffs. Lower costs mean that  
5 people can afford coverage but also that there are  
6 more restrictions to the care for those who are  
7 covered. Positive attributes around access or better  
8 financial access with low copayments and no  
9 deductibles. New products have been developed to  
10 address the demand for access to doctors. Better  
11 coverage for drugs, for example in the Medicare  
12 population, and also to health services.

13                   Also, some of the studies we looked at  
14 showed that there was better access to mental health  
15 services with low-cost sharing.

16                   Some of the negative attributes are  
17 that they're narrow towards the doctor and referral  
18 restrictions, longer travel distances, formulary  
19 restrictions, restrictions on approvals for mental  
20 health services, unmet medical needs, especially for  
21 the rural population, and rural areas are still a  
22 problem under managed care.

23                   The story of cost-managed care appears  
24 to have slowed the rising health care costs and are  
25 largely different from the purchaser and the  
26 competitive market. Nationally, costs increased by  
27 11.5 percent in 1991. Those increases fell steadily  
28 to .5 percent increase, in 1996 and then it was back

1 up slightly in 1997 to a 2.1 percent increase which  
2 is about the rate of inflation. The story at the  
3 state level, we think, is comparable, although it has  
4 to be pieced together at the state level.

5                   For large purchasers, we know that  
6 there have been net reductions and weighted average  
7 premiums since 1993 which range between 1 percent and  
8 20 percent before inflation. Those are for  
9 purchasers like PBGH, CalPERS, Pacific, U.C.  
10 Stanford and the like.

11                   With a small group market, we know that  
12 the HIPIC rates have also declined, although they had  
13 a slight increase in 1998 or for 1998, so we infer  
14 that carriers who want to be competitive in this  
15 multiple market have also lowered their rates  
16 although we don't have that data.

17                   Using the federal employee health  
18 benefit program to make a national comparison, we  
19 looked at FEHBP HMO rates in California and saw that  
20 they have declined more or increased less than the  
21 national average for the last five years.

22                   Information about the underlying cost  
23 structures suggests California greatly -- generally,  
24 I'm sorry -- has a lower cost structure than  
25 nationally including fewer hospital days, hospital  
26 beds, days per thousand, but more physicians per  
27 100,000 although that's been increasing slower, and  
28 that variations in utilization of hospital days and

1 visits suggests that there may be room for continued  
2 improvement. Typically, between the least efficient  
3 medical groups and the most efficient medical groups,  
4 the least efficient medical groups were using twice  
5 the resources of the most efficient.

6 There are also concerns related to cost  
7 that -- about whether the cost containment is leading  
8 to the problems in quality. That's it.

9 CHAIRMAN ENTHOVEN: Thank you.

10 Dr. Alpert.

11 DR. ALPERT: Actually, I know we were  
12 going to talk about the summaries and about the  
13 papers, but the summary that I heard from Sara, which  
14 I thought was excellent, and I want to specifically  
15 talk about the access summary. What Sara said was  
16 excellent. I know it doesn't relate totally to the  
17 one that's in the executive summary and I just want  
18 to bring up one sentence, the last sentence which is  
19 on page 1 of the summary. Actually I would prefer  
20 for me that Sara -- when Sara said simply be the  
21 summary for access, unless I missed something, I  
22 thought was superb and presented a balanced side in  
23 an educational way.

24 Last of the series: "As a result of  
25 cost containment, managed care has likely improved  
26 overall access by preventing more people from  
27 becoming uninsured."

28 To me that's speculation that requires

1 impressions and you could analyze it based on current  
2 data as to whether or not the totally uninsured has  
3 increased, as to whether or not the percentage of  
4 employed uninsured versus unemployed uninsured has  
5 increased. The data that I know of actually shows  
6 that the employed uninsured fraction has increased.

7 But this is a -- I think this sentence  
8 is speculative at best and it was not included in  
9 what Sara said.

10 CHAIRMAN ENTHOVEN: Well, there is  
11 research literature that tries to understand why are  
12 people are uninsured and one of the important factors  
13 is the cost of coverage and perhaps we should have  
14 brought the citation -- Rick Kronik at U.C. San Diego  
15 has done a lot of writing on that.

16 MS. O'SULLIVAN: I don't think that  
17 would take care of it though because I think  
18 everybody would agree that cost is the reason people  
19 are uninsured. However, the fact that cost has come  
20 down or inflation has slowed down over the last few  
21 years or we don't even know if it's adequate to bring  
22 in any uninsured people. So I don't think there's  
23 going to be enough supporting data. What I said  
24 earlier was that we're actually concerned that people  
25 are getting -- insured people have poorer access to  
26 care than they did previous to all this cost cutting  
27 in managed care.

28 DR. ALPERT: I guess my comment was

1 just in concert with what Ms. Griffiths said before.  
2 I didn't find anything in the text of the paper to  
3 specifically -- from which I would have drawn that  
4 sentence as a summary. If there is something that  
5 should be in the text and that explains it logically,  
6 then fine, I'll be happy to hear it.

7 MR. ZATKIN: The CBO, the Congressional  
8 Budget Office, has looked at the issue in terms of  
9 the impact of health care cost increases on the  
10 number of uninsured. They have data to relate it to.  
11 And while there may be intervening factors in terms  
12 of what's going on, basically like when health care  
13 costs go up a certain amount more people drop off  
14 coverage, and to the extent managed care has  
15 moderated those increases, I think it's helped keep  
16 people from being uninsured, which is not to say that  
17 it's covered -- it's not to say we don't have a lot  
18 of uninsured, we do, and I guess the point is we  
19 might have even more but for the cost control. And I  
20 think that's an -- that's probably an accurate  
21 statement that we would have more in the absence of  
22 managed care.

23 DR. ALPERT: I guess I'm just troubled  
24 by the speculative nature of that which is what I'm  
25 essentially saying in the way this is phrased it  
26 seems to imply it as fact.

27 CHAIRMAN ENTHOVEN: Okay. Well, we'll  
28 get the CBO study.

1 Peter Lee.

2 MR. LEE: Three comments.

3 CHAIRMAN ENTHOVEN: Page?

4 MR. LEE: Seven. First the general:

5 One of Maryann's points separate from cost is the  
6 inability to shift cost implications for access for  
7 the uninsured -- and the implication for the public  
8 sector in picking it up is one of the issues I heard  
9 Maryann raising which is separate from the  
10 implication of more coverage for people who are  
11 covered and that's an issue I think isn't addressed  
12 much in here. It's a side access issue from the  
13 public sectors coverage for the uninsured. So that's  
14 a response claim.

15 Two comments and I'm going to do what I  
16 -- well, first page 3 contrast to page 12. And this  
17 is to note briefly an observation relative to managed  
18 care versus fee for service. On page 3 the second  
19 paragraph under "unmanaged care." Some of the  
20 observations here are just as true for managed care  
21 as for unmanaged care such as the intensive use of  
22 intensive care in this country versus other  
23 countries. But it's sort of set up as an unmanaged  
24 care issue as opposed to a managed care.

25 Similarly on page 12, publishing the  
26 physician outcomes, the introduction absolutely notes  
27 that this is relevant under non-managed care as well  
28 as under managed care, but it's set up here as one of

1 the good things about managed care and those were  
2 examples to me for staff to look into and rewrite not  
3 contrasting managed care has all this good stuff and  
4 fee for service has this bad stuff, but try to have a  
5 more balanced discussion.

6 The second, and I again I've got a lot  
7 of comments that staff will get in requests for  
8 citations.

9 DR. ROMERO: We've allowed your  
10 comments, Peter.

11 MR. LEE: Yeah, thanks.

12 The bigger concern about the paper is  
13 related to page 13 and potential solutions. I don't  
14 think this is appropriate, quite honestly, to have in  
15 this paper any potential solutions. That's exactly  
16 what our discussion's about, potential improvements  
17 to the managed-care system. And as soon as they're  
18 listed as potential as part of our Task Force's  
19 report, then someone out in the world says the State  
20 Managed Care Task Force said a potential solution to  
21 "X" is this. And I would suggest that entire section  
22 G is great food for thought to make sure our ERGs do  
23 our work and consider these issues, but I would pull  
24 it out and the other example of that. Besides that  
25 whole section G is page 20, and this is where it came  
26 up, specifically, at the very top of page 20, related  
27 to prescription drug and formularies. There's a  
28 recommendation, in essence, of what a better model

1 would be about formularies and that better model  
2 recommended is the formulary of medical group and  
3 IPAs. I don't know. You know, I'd like to talk  
4 about that some, but the background papers shouldn't  
5 be saying better models. So that's an overall.

6 CHAIRMAN ENTHOVEN: Is there general  
7 support for the idea of deleting section G? May I  
8 see a show of hands.

9 Okay. I'll delete G.

10 MR. ZATKIN: I would agree and to the  
11 extent of some of the other papers, I'm afraid I  
12 won't be here for some of the discussion on some of  
13 them, but I believe these are all background papers  
14 as I understand it and we should pull out what looks  
15 like a recommendation and include that in an  
16 appropriate discussion and place.

17 CHAIRMAN ENTHOVEN: Okay. Bruce  
18 Spurlock.

19 DR. SPURLOCK: Thank you. I want to  
20 make two general points in the quality arena and then  
21 it is -- I'm going to talk generally, but it's  
22 identified on page 1 under B, "Perceived Problems."  
23 And really, in my view, what's driving a lot of  
24 discontent out there is the perception of quality  
25 versus the reality. While we talk about perception  
26 here I don't think it's really highlighted to the  
27 extent that it really is the major driver in what's  
28 going on with quality. If you ask yourself why in

1 the face of multiple studies where there's a wash,  
2 where there's not a clear consensus, why is that  
3 perception at multiple levels, at the consumer, at  
4 the physician, at the hospital administrator, at the  
5 nurse, why at multiple levels, even in the face of  
6 all this data, there's still the perception that  
7 quality is not necessarily what it could be or what  
8 it should be. I think part of that is because the  
9 quality in talking in other papers aren't being met.  
10 But I think we need to highlight in the background  
11 paper much more strongly that this perception is  
12 really overwhelming in multiple areas, not to be  
13 remiss, not to represent the views of those providers  
14 who are coming up whether they're accurate or  
15 inaccurate, it's just that the perception problem is  
16 so great it's really driving much of our  
17 conversation.

18                   The other point that really comes up in  
19 discussion -- maternity stays is a good example, and  
20 that's on page 6 and it could be highlighted in a  
21 very general context, not necessarily about maternity  
22 stay, that's a good example is this notion of what we  
23 do with managed care is look at whole populations and  
24 what providers and physicians and the fee-for-service  
25 look at is individual health and they're very  
26 different constructs and some of the tension that  
27 we're having is trying to look at population health  
28 measures from the individual perspective and I think

1 the maternity stay really highlights that because in  
2 the article that describes the Washington State  
3 example from 1991 to 1994 there was an accompanying  
4 editorial that said, listen, you can have guidelines  
5 about early discharge from others, but you have to  
6 have clinical judgment there, as well, and that, in  
7 absence of clinical judgment, we have a system that  
8 is built for a population that does not treat  
9 individuals very well. The longer we try to do  
10 guideline development, which I'm a big supporter of  
11 guideline to medical impact and all of that pathways,  
12 but we have to leave the notion of flexibility and  
13 patterns of utilization as I mentioned before because  
14 when you look at individual patients they don't all  
15 look alike. And with maternity stays, the editorial  
16 recommended that physicians simply add a couple more  
17 variables into their judgment decision. The patients  
18 wouldn't necessarily come back any sooner. They  
19 would have to just screen the ones that needed to  
20 stay in longer versus the ones that didn't need to  
21 stay longer and we would have the same outcome and  
22 fee-for-service model versus the managed care model.

23 I think that's something we need to  
24 highlight in this report, the population versus the  
25 individual tension is going to exist, but we have to  
26 retain a balance between those two notions.

27 CHAIRMAN ENTHOVEN: Helen  
28 Rodriguez-Trias.

1 DR. RODRIGUEZ-TRIAS: Yes. In the  
2 whole section on cost, there is no discussion of the  
3 cost to the consumer. And I think this is really  
4 really important. I mean, we're always looking as if  
5 the consumer was the purchaser and I think we need to  
6 get away from that. I think the data I have seen is  
7 that the out-of-pocket costs to the subscribers have  
8 risen as managed care has and I don't know if that  
9 still holds from a couple of years ago when the study  
10 was done, but I think that needs to be looked at.

11 MS. SINGER: Can you provide the data?

12 DR. RODRIGUEZ-TRIAS: Yes. I'll have  
13 to look it up, yes. There's a survey.

14 CHAIRMAN ENTHOVEN: There's a series of  
15 health care financing reviews and an annual article  
16 on health expenditures which has shown the percent of  
17 health care expenses paid by consumers out-of-pocket  
18 has steadily decreased.

19 Moreover, I think it's a fair  
20 generalization. I'm just trying to get a handle on  
21 how to deal with it that fee-for-service coverage,  
22 whether preferred provider or indemnity coverages,  
23 just simply do, it's a well-known obvious fact, rely  
24 much more on deductibles and co-insurance. I mean,  
25 in any employment group where there's a choice, the  
26 HMOs don't have deductibles. In PERS, I forget in  
27 PERScare whether it's 200 or what or several hundred  
28 dollars deductible -- many of you must be on PERScare

1 and can tell me. Those produce less consumer  
2 out-of-pocket spending if you have HMO coverage.  
3 Right?

4 DR. RODRIGUEZ-TRIAS: But again, we're  
5 making HMO synonomous with managed care and I think  
6 that's -- again we have to look at the models of  
7 that.

8 CHAIRMAN ENTHOVEN: Right. All right.  
9 Any other members? Yes, Maryann.

10 For a minute I had the exciting thought  
11 that we were finished with this paper.

12 MS. O'SULLIVAN: Well, I will take care  
13 of that. Actually, to me this paper is majorly --  
14 would be majorly problematic for us to sign off on  
15 and some of the other ones that are going to follow  
16 are, you know, two or three pages with  
17 recommendations where I will have the ability to say,  
18 well, yeah, you know, we like this and this, we don't  
19 like this and this.

20 This is -- to me this is sort of like  
21 an assignment to somebody to go out and find the best  
22 things you can say about managed care and bring it  
23 back to me and that's what this looks like to me.  
24 And I can go through and sort of, you know, under  
25 summary of managed care issues. "HMOs excel at  
26 preventive care and early diagnosis." I don't know  
27 that. I mean, the idea is proposed to do that, and I  
28 think some of them do do that, but to just have a

1 sentence that says that with no footnote, no nothing,  
2 I don't think it works.

3 On page 8 it's a customer service piece  
4 that lists all the wonderful things that some HMOs  
5 are doing to make customers happy. And to me it kind  
6 of goes on like that, I mean there's a lot.

7 Page 7 there's some stuff on churning,  
8 it talks about how for big -- big purchasers churning  
9 is becoming less and less a problem. It doesn't  
10 talking about where churning is a issue.

11 I have a recommendation which is that  
12 we send this back to the drawing board and ask that  
13 staff produce something that's about two pages each  
14 on quality of access and on cost, that are really  
15 almost what Sara presented when she started today so  
16 that people can get down to real language questions  
17 and say this is okay, this is what we think we ought  
18 to be saying about quality, and this is what the pros  
19 and cons of things that have happened as opposed to a  
20 lot of verbiage here and not a lot of -- not --  
21 anyway, that's what I have to say.

22 CHAIRMAN ENTHOVEN: I just wonder if  
23 that would be considered responsive to the  
24 legislative request for a paper on the impact on  
25 quality access to cost.

26 MS. O'SULLIVAN: Frankly, I think it  
27 would be more helpful. I think more people would be  
28 able to grapple with a couple or few pages on what's

1 happened in terms of quality as opposed to try -- I  
2 don't know what somebody would do with this. I don't  
3 know if I was legislative staff how I would decide  
4 what solutions to craft based on --

5 CHAIRMAN ENTHOVEN: Can I ask Martin  
6 and Diane.

7 MS. BOWNE: I have a very different  
8 point of view on this particular paper. While I will  
9 certainly agree with the early comments on spin and  
10 balance, I think it's unquestionably referencing  
11 documented peer review studies. It's well footnoted.  
12 While I think that one could say, perhaps, it could  
13 be more balanced, I think that we've got a lot of  
14 valuable information here. And if we, as  
15 representatives of the public and representatives of  
16 their interest groups, are afraid to get things out  
17 in the table in black and white and agree that we  
18 have differences but not sweep it under the rug and  
19 not present the evidence, I think we're doing  
20 ourselves a great disservice and I think one of the  
21 purposes of a background paper like this is to bring  
22 out what is in the literature, what has gone out  
23 before, so that we can make concerned decisions about  
24 what should happen in the future.

25 Now I caveat that with recognizing that  
26 there could be, certainly, places where there is more  
27 balance and different perspectives, but I think it's  
28 good in the background paper to have the kind of

1 documented information that we have been given.

2 CHAIRMAN ENTHOVEN: Okay. Lee and then  
3 Finberg and then Griffiths.

4 MR. LEE: My tendency would be also to  
5 more balance rather than having it be a much much  
6 shorter piece. That's one response to those issues.

7 And the other is one of the things that  
8 came up in a prior paper and in this paper is sort of  
9 where does the public perception, where do the  
10 consumers actually fit in this? And I'm not -- it  
11 doesn't come out enough, and I think that one of the  
12 places that it might come out in terms of the report  
13 is not just -- Jeanne made the observation in the  
14 last paper that consumers have one paragraph in some  
15 ways. The whole reason we're here is that there are  
16 real concerns that people are having troubles, some  
17 argue they are perception troubles as opposed to  
18 reality troubles, but that's some of the debate we're  
19 going to be having.

20 But I think potentially in the report  
21 the section on observations of public perceptions  
22 might be a whole chapter, expanded. Not just the  
23 Task Force findings the survey reported, but a  
24 summary of the whole range of observations. How is  
25 this actually hitting at the ground?

26 I mean, consumers on the street, you  
27 know, hear things like access cost and glaze over.  
28 The perception issues, the concern issues, the

1 potential trouble issues are ones that I think we  
2 need to flesh out because that really frames,  
3 hopefully, all the recommendations that we're making.

4                   So I would suggest that, yes, we  
5 bolster it in each of these pieces but, in  
6 particular, it makes sense to have, as part of the  
7 background, a whole chapter in some ways framing  
8 their perceptions, concerns, problems that frame all  
9 the recommendations, then follow that.

10                   So that's a comment that's really not  
11 specific to this paper, but bringing issues, you  
12 know, to the fore.

13                   CHAIRMAN ENTHOVEN: One of the things  
14 we are doing is a literature review of the -- there  
15 are quite a few other surveys out there and so we're  
16 doing that to -- balance that -- to accompany, I  
17 should say, the report on our own survey.

18                   MR. LEE: And I think that's very -- I  
19 mean, I think some of the studies that we've been  
20 given by CCHRI and EBGH have particular elements in  
21 the survey results that, to me, say part of why we're  
22 here. To give you one example if I could, is that I  
23 think it was CCHRI noted that when asked what  
24 percentage of the respondents had a problem getting  
25 access both they and their doctor thought was  
26 necessary -- not just the patient -- 9 percent said  
27 they had a big problem and 14 percent more said a  
28 problem. If one out of 10 people said they had a big

1 problem they and their doctor think are necessary,  
2 that's part of why we're here.

3                   And so that's the sorts of  
4 observations. And the other observation being used  
5 sweepingly in writing about managed care is the big,  
6 big differences between managed-care plans and that's  
7 one thing I think that we need to -- part of the  
8 reason I respond to managed care being used so  
9 sweepingly is that there are differences and part of  
10 what we should be looking at is trying to raise the  
11 floor across the board.

12                   CHAIRMAN ENTHOVEN: Finberg. Jeanne  
13 Finberg.

14                   MS. FINBERG: I guess I have two sort  
15 of types of comments. The first is along the do we  
16 have a shorter paper or longer paper with better  
17 balance? I think we can go either way on that. I do  
18 think balance is necessary. But Maryann's suggestion  
19 is appealing in one way in that this discussion  
20 highlights the difficulty of us approving long  
21 documents because of the diversity of views.

22                   And so what's appealing about a shorter  
23 paper is that it makes it seem more possible to me  
24 for us to reach consensus on a shorter document. So  
25 that's just one thing I'll say about the difficulty  
26 of this process and, you know, the importance of  
27 discussing the critical issues and that this is the  
28 first time we're really sort of getting down to that

1 business and how hard it is.

2 And that leads me to my other comment  
3 in terms of is this a background paper or not? I  
4 don't have the legislation in front of me, but my  
5 understanding of the legislation to give a report on  
6 quality access and cost wasn't that that's one  
7 background paper. That is a very broad mission for  
8 this Task Force and it seems like it's the conclusion  
9 of the Task Force in that each of these issues would  
10 lead to extensive discussion and recommendations.

11 So I think it would be helpful to take  
12 a look at that language to see if, really, we are  
13 supposed to have one paper that discusses quality  
14 access and cost because I thought it said to report  
15 on the following subjects.

16 DR. ROMERO: Can I -- I'll read from  
17 the legislation.

18 MS. FINBERG: Yes, thank you.

19 DR. ROMERO: And I'll give you a little  
20 bit extra just to put it in context.

21 The governor helps the Task Force to  
22 research and report on all the following to be  
23 generated for 1988.

24 The second of those following is  
25 whether the goals of managed care provided by health  
26 care service plans are being satisfied including the  
27 goals of controlling cost and improving quality and  
28 access to care.

1 MS. FINBERG: Yeah. See, I think those  
2 are very basic, important questions and it does frame  
3 what our task is. That to me isn't a background  
4 paper and I think the idea have we achieved those  
5 goals, I do believe that that is what we need to be  
6 answering, but I guess, you know, that those are a  
7 threat throughout the entire report.

8 CHAIRMAN ENTHOVEN: Diane Griffiths.

9 MS. GRIFFITHS: My comments are  
10 actually pretty well covered by Jeanne.

11 I share the view that a shorter version  
12 is more likely to achieve consensus. I don't think  
13 that necessarily means that we ought not to mention  
14 the literature insofar as it expresses findings of  
15 the authors concerning particular points.

16 But my concern, as has been indicated  
17 by others as well who have the same concern, is that  
18 in many, many cases we have then statements of  
19 support for managed care without any citation or  
20 authority. I'm just looking at page 2 of this  
21 document and I see four different -- many citations  
22 on this particular page have several footnotes  
23 supporting people's criticisms of managed care and  
24 then each of the paragraphs concludes with a positive  
25 statement about managed care with no citation of  
26 authority. And those seem fairly gratuitous to me.  
27 If we're doing a literature search, we ought to  
28 document the positive statements about managed care

1 likewise or we ought to leave them out or at minimum  
2 qualify them as the opinion of people who support  
3 managed care.

4 CHAIRMAN ENTHOVEN: Michael Shapiro.  
5 Do you have --

6 MR. SHAPIRO: Yes, I do. One of my  
7 thoughts is that at this portion of the documents  
8 being developed I think the less controversy the  
9 better because these aren't the recommendations and  
10 here you're suggesting maybe balance. I would err on  
11 the side of trying not to put too much into this  
12 document because if others find imbalance later, it  
13 can be used to discredit the recommendations.

14 Let me give you one example where I  
15 think it might be worth to err on the side of  
16 brevity. On pages -- starting on page 18 dealing  
17 with formularies. I have no problem with the last  
18 line on that page in terms of the benefit of  
19 formularies reducing costs. I have significant  
20 concerns with the rest of the discussion on  
21 formularies. And let me give you some examples.

22 It starts out on the next page, 19. In  
23 theory, physicians essentially used evidence based  
24 medicine to evolve formularies. It then used  
25 PacifiCare as an example of an HMO that relies on  
26 evidence-based information to develop formularies and  
27 then suggests that PDMs have conflicts of interest.  
28 And I will supply the committee with transcripts

1 where, in fact, PacifiCare was accused of biases  
2 developed against formularies giving drug discounts  
3 driving the decisions. And PDM complaint is they  
4 supplied evidence based formularies to HMOs who  
5 modified them based on drug discounts.

6                   So I think their conflict of interest  
7 throughout the development of formularies is not one  
8 that PDM and their own drug manufacturers and some  
9 HMOs are being criticized for the way they manage  
10 their formularies.

11                   Another concern I have is one of the  
12 few research efforts done on formularies cited here.  
13 It's footnoted in 65. It's then attacked without any  
14 substantiation right after that.

15                   And the first line in that, the  
16 criticism is: "However, this study ignored drug  
17 discounts."

18                   In fact, the very point of the study  
19 was that drug discounts were driving formularies  
20 which, in fact, were having adverse health outcomes.  
21 So I'm not sure what the point is that the study  
22 ignored drug discounts because that was the very  
23 basis of how these formularies were being developed  
24 in part. So I'm concerned about no support for the  
25 criticism of that and why that is there.

26                   We also have another proposed solution  
27 in that next paragraph where it states in the end,  
28 "these patients may need special monitoring or may

1 need approval to continue with non-formulary drugs."

2 I'm not sure how you want to deal with  
3 that, but it is a proposal that may not be  
4 appropriate in this background paper.

5 The next paragraph talks about  
6 Lifeguard, dealing with patients who want  
7 unnecessary, non-formulary drugs. I'm not sure what  
8 "unnecessary" means. Most of these patients have had  
9 a drug prescribed by an attending physician who  
10 thinks it's necessary, then found non-complying with  
11 the formulary. That appears to be the case, they say  
12 you want that drug, you pay for it. So words like  
13 "unnecessary" concern me.

14 PacifiCare is given as an example of a  
15 good model where they approve 90 percent of their  
16 requests for non-formulary drugs. We've had hearings  
17 where the major focus of public perceptions were that  
18 10 percent they don't approve, notwithstanding  
19 physician efforts over exceedingly long periods of  
20 time seeking exceptions based on side effects and  
21 other adverse impacts on that patient. The press is  
22 focusing on that 10 percent in terms of consumer  
23 perceptions. So I'm not sure if a 90 percent record  
24 is good. And while they may prove 90 percent in a  
25 short time, you've had excessive delays on that 10  
26 percent in terms of the amount of time PacifiCare and  
27 other HMOs deal with that.

28 We've also had -- the last line says,

1 "most doctors agree to convert." We've had  
2 physicians testify in legislation they're harassed if  
3 they seek exception and that they're simply not going  
4 to suffer that harassment and will acquiesce to  
5 formulary drugs not to impact on their patients. So  
6 the balance on this, I think, is missing.

7                   Again, who should develop the  
8 formularies? We're getting a lot of controversy now  
9 on capitated drug budgets. Medical groups who do not  
10 use EMT committees, who do not use expert committees,  
11 to develop formularies are simply suffering financial  
12 losses directly associated with their capitated drug  
13 budgets, making medication decisions without  
14 expertise. It goes with the issue of eliminating the  
15 recommendation on the next page. But there's great  
16 controversy about delegating this function to the  
17 medical group who may not have the resources or  
18 expertise to really have a reasonable formulary in  
19 place.

20                   Finally, it says on page 20 top,  
21 "pharmacists must call physicians." In fact,  
22 pharmacists do not have to call physicians. The  
23 controversy is they're getting kickbacks and other  
24 incentives from physicians to make formulary changes,  
25 notwithstanding the medical necessities associated  
26 with those drugs that have been prescribed by  
27 physicians.

28                   So this is a very controversial area.

1                   This goes to the difficulty of striking  
2 a balance in areas like this. I'm not sure whether I  
3 will supply the information I have. I'm not sure if  
4 this group is ever going to come to a recommendation  
5 on formularies. One may suggest it may be areas  
6 appropriate for striking a balance, others where if  
7 not we can reach that level of specificity, what's  
8 the point in trying. I leave it to the group to  
9 decide.

10                   CHAIRMAN ENTHOVEN: May I just ask  
11 Martin as our legislator, who is our resident  
12 legislator, your thought about this whole thing about  
13 the paper; that is, should we be trying for something  
14 that is very brief, that is two or three pages each  
15 on access and cost or should we work with the paper  
16 we have but make sure everything is either documented  
17 and both documented and balanced? What is your  
18 general advice to us on that?

19                   HONORABLE GALLEGOS: I'll make a  
20 comment that is probably going to please staff people  
21 who are here and that is that probably a more brief  
22 paper would -- I mean as long as it's balanced and as  
23 long as it's well documented and footnoted and  
24 there's no opinion or commentary in there that has no  
25 basis, I think would be adequate.

26                   Now, I mean for those of us and staff  
27 who just love reading long, endless documents in  
28 addition to all the other that we have to read, as

1 long as it was focused and well footnoted I think it  
2 can provide valuable information, but you know again,  
3 it's got to be balanced and not trying to be  
4 persuasive and argument but rather try to be more  
5 factual and informative in the content.

6 I don't know if that helps.

7 CHAIRMAN ENTHOVEN: Yeah.

8 DR. ROMERO: I'd just like to follow  
9 up.

10 There are several other descriptive  
11 pieces that were required by legislation including  
12 the one we talked about an hour ago. Would you  
13 extend that characterization to those other pieces  
14 also?

15 HONORABLE GALLEGOS: I'm not the author  
16 of the legislation and I don't want to put words  
17 into, you know, Assembly Member Richter's mouth with  
18 regards to his intent.

19 I'll just speculate and give my opinion  
20 and say yeah. Yes, I would in all those instances  
21 think that that would provide for better information  
22 overall.

23 DR. ROMERO: Okay. Thank you.

24 HONORABLE GALLEGOS: You might want to  
25 consult with the author just to be on the safe side  
26 because I don't want to try to read his mind and  
27 misinterpret his intent

28 DR. ROMERO: But as a member of our

1 target market, you know, as a proxy for the customer  
2 for this report, which is a member of a legislative  
3 body, you feel for the most part shorter is better.

4 HONORABLE GALLEGOS: I think staff  
5 would probably agree with that, too.

6 DR. ROMERO: Thank you.

7 HONORABLE GALLEGOS: And just to  
8 clarify, too, my position here on the Task Force is  
9 not one of legislative, there are certainly no  
10 provisoes for that. I'm here in the capacity of a  
11 professional provider who operates in the system.  
12 But, I mean, I'm happy to lend any input that I can  
13 from the legislative perspective.

14 DR. ROMERO: I take the opportunities  
15 any time as I find them.

16 HONORABLE GALLEGOS: That's fine, Phil,  
17 no problem.

18 MR. ZATKIN: Alain, I wanted to make a  
19 point on the style of the document. It refers in  
20 several instances to particular HMOs and we were  
21 referred to, on occasion, quite positively. But I  
22 guess I would recommend against that for a couple of  
23 reasons: One, I don't think you conducted a  
24 comprehensive survey of what the practices are. So  
25 you may not have found the best ones or the worst  
26 ones for that matter. And I would -- I guess I would  
27 recommend against at least naming the plans in any  
28 event, and I guess I would be cautious in terms of

1 the example Michael noted some difficulty where  
2 providing examples about perhaps a further analysis.

3 CHAIRMAN ENTHOVEN: Okay. Ron  
4 Williams.

5 MR. WILLIAMS: Yeah. Just a brief  
6 comment that I think, given the guidance that seems  
7 shorter is better, I think we face a pretty tough  
8 challenge, particularly around this particular  
9 section. The issues of quality of access and cost  
10 are really critical issues and they turn out to be,  
11 to some degree -- I'll use the word "driest output"  
12 of the issue. They don't tend to be necessarily  
13 consumer-oriented -- it's much more research-based --  
14 yet it provides a very solid fact base with the  
15 appropriate balance in it.

16 So I just encourage you as you move  
17 toward brevity that we have to keep a very solid  
18 research base in the final document because this is  
19 one of the most critical dimensions of what we have  
20 to say. It's really what does the research say about  
21 quality and about access and cost, and I think the  
22 pharmacy discussion was a very important one and the  
23 cost issue there. It probably illustrates this whole  
24 dilemma between how do you provide the right access  
25 and quality when at the same time, generally, we're  
26 saying pharmacy costs go up at 20 to 30 percent a  
27 year, and at the same time the system has to find a  
28 way to make sure the patients are receiving the

1 necessary pharmaceuticals to make sure their health  
2 status is maintained.

3 MR. LEE: I think brevity is a great  
4 thing but also people will only read so far and as I  
5 understand the proposed format, which is one I didn't  
6 even think about, the executive summary of each of  
7 these papers is what would be in the quote, unquote  
8 front and the however long it is -- and I still like  
9 brevity -- would be an appendix.

10 I mean, I will care a lot more on the  
11 next draft about what's in the executive summary as  
12 well as what's in the body, but the executive summary  
13 is what I would suggest legislative staff are going  
14 to read, what most people are going to read.

15 I'm worried about the supported  
16 material being biased or slanted or whatever, as  
17 well, but the executive summaries, which are  
18 generally two pages -- you know, I think that's a  
19 good model -- are what most people are going to read.  
20 And does that mean we still need or don't need the  
21 extent of the backup? I think the backup's  
22 important, but I encourage you as staff has done, to  
23 look at those executive summaries. That's what I'm  
24 going to care about next time, along with a lot more  
25 than the backup. I want balance there and the  
26 executive summary is what we're going to need.

27 CHAIRMAN ENTHOVEN: Ms. O'Sullivan.

28 MS. O'SULLIVAN: On the funding

1 research question I think it's important where we've  
2 got these to use it. But also to acknowledge that  
3 one of the big problems that we face is the lack of  
4 data and I know this piece relies on the Hal Luft  
5 studies and they go back pretty far and are looking  
6 at HMOs in not mature markets. My understanding is  
7 that once a market is mature is when we really start  
8 seeing the competition and the costs being driven  
9 down and I just -- if we're going to live with those  
10 kinds of studies I think we need to acknowledge that  
11 the world has changed so fast they were almost done  
12 in a different world than the world that exists  
13 today.

14 CHAIRMAN ENTHOVEN: I thought we had a  
15 statement in there to that effect.

16 MS. O'SULLIVAN: I'm just saying as  
17 we're going in terms of what is next in terms of a  
18 shorter paper.

19 MR. LEE: 15-minute warning.

20 CHAIRMAN ENTHOVEN: Helen  
21 Rodriguez-Trias.

22 DR. RODRIGUEZ-TRIAS: I see this report  
23 as also being helpful for people in the field in  
24 general and I would vote for this side of keeping  
25 much of the research that has been done in appendices  
26 or however. We might decide for the readability of  
27 it that this work should not get lost, that it should  
28 be available for people out there that are going to

1 use it.

2 CHAIRMAN ENTHOVEN: Okay. J.D.  
3 Northway.

4 DR. NORTHWAY: Executive summaries are  
5 what people will read. You need to make certain that  
6 the data is in the backup and so people can make the  
7 same conclusions or draw the same summaries that we  
8 drew from the data that's in the whole paper.

9 CHAIRMAN ENTHOVEN: Okay. Brad  
10 Gilbert.

11 DR. GILBERT: Just very quickly to add  
12 to Steve's comment: I don't thing specific HMOs  
13 should be mentioned at all. There are many HMOs that  
14 don't do drug discounts and rebates and they might  
15 have a reasonable process which then views them as  
16 the example; you have others that don't.

17 So I would suggest when you want to  
18 make a comment you just give a general statement  
19 about the range of types of activities that are done  
20 because, I mean, in the pharmaceutical area the range  
21 is from HMOs that have absolutely no relationships in  
22 terms of those financially to those that are  
23 significantly impacted.

24 The State of California uses rebates  
25 and direct discounts extensively in the Medical  
26 formulary, for example. So I would avoid any  
27 specific naming and simply provide a range, a general  
28 range of what the different methodologies are.

1                   CHAIRMAN ENTHOVEN:   Okay.   Alpert.

2                   DR. ALPERT:   Just a simple exclamation

3 point after Brad's.   Under customer service the best

4 HMOs stress customer service, the best HMOs.   The

5 next sentence starts:   "Lifeguard health care."   So

6 you can.

7                   CHAIRMAN ENTHOVEN:   We accept the point

8 that will help us to shorten it.   All specific

9 references to specific HMOs.

10                  MR. LEE:   You can see that in an

11 upcoming advertisement, can't you?

12                  MS. O'SULLIVAN:   Task Force says.

13                  CHAIRMAN ENTHOVEN:   That will help us

14 approach Maryann's goal.

15                  DR. ROMERO:   The worst of all possible

16 worlds would be if the only specific HMOs mentioned

17 were those who have representation   on this Task

18 Force.

19                  CHAIRMAN ENTHOVEN:   Okay.   Barbara

20 Decker.

21                  MS. DECKER:   I agreed with what Helen

22 had said a minute ago about -- I mean, one of the

23 exciting things to me reading these papers was this

24 is great information I can use in different ways that

25 was very informative and helpful and I guess now even

26 though we have a great consensus going about no

27 specific references to HMOs, I'm a little concerned

28 about if we just say the range is "X" versus A to Z,

1 have we -- we're not giving a cite, we're just saying  
2 it's A to Z, have we been undermined or our  
3 credibility as to how did we decide the range is A to  
4 Z? I don't want to mention the best HMO, I agree,  
5 but I'm concerned saying it's this and not having any  
6 actual data to support why it's this.

7 MR. LEE: An answer to that is I think  
8 it's a worthwhile introduction to note that the staff  
9 did some survey on specific plans and some examples  
10 are given, but decision was made to never cite the  
11 specific plan for reasons that the citations that are  
12 the important ones here aren't so much to Lifeguard  
13 with PacifiCare, but they're to where we're making  
14 broader conclusions that "X" studies says we make  
15 broader assertions. So I think that's relatively  
16 easy to cover.

17 CHAIRMAN ENTHOVEN: Helen.

18 DR. RODRIGUEZ-TRIAS: Is there also  
19 some surveys out there, I mean, this recent one which  
20 I just saw on the newspaper, I haven't seen the  
21 actual report on the NCQA on looking at the various  
22 indicators, you know, speak specifically to  
23 particular plans. So I think where there's  
24 literature backup for a survey approach, it may be  
25 appropriate to include that kind of information.

26 MR. ZATKIN: I think it's in "U.S. News  
27 and World Report" next issue it's coming out.

28 MR. LEE: Already out.

1                   MR. ZATKIN: But that there are  
2 several, that's one. You know when you legislate you  
3 legislate, and please correct me, but you typically  
4 legislate on the worst practice not the best. And  
5 the issue is will the worst practices correct  
6 themselves without legislation. That's always where  
7 the legislature finds the dilemma and we need to try  
8 to help in dealing with that. Which of these -- it  
9 isn't that Lifeguard can do this so well, it's that  
10 somebody else is doing it so poorly and what needs to  
11 be done in order for that to improve. That's the  
12 fundamental issue that we face in all of these areas.

13                   So as I understand it, no comprehensive  
14 survey has been done on practices. We're mostly  
15 relying on sort of what is generally known about the  
16 best practices and maybe the worst. It's coming up  
17 through the ERG group process I hope.

18                   CHAIRMAN ENTHOVEN: Let me just say  
19 we're heading up to the 11-minute warning. We've got  
20 10 minutes to go.

21                   MS. SEVERONI: I wanted to pick up on a  
22 comment that Ron Williams made that sort of  
23 crystalized the thought in my mind and that is in  
24 talking about the areas of quality, cost and access  
25 as areas that, at least as we've presented them and  
26 talked about them today, are quite dry and less  
27 consumer-focused. And I think we maybe want to shine  
28 a light on that a little bit. In particular, I was

1 starting to think about the quality issue and how I  
2 watched health care organizations struggling now to  
3 try to live under the requirements of all of these  
4 organizations and regulating agencies that are asking  
5 for outcomes and to measure and this and that and the  
6 other thing. And that each and every time I see  
7 these kinds of measures presented to the public, they  
8 really don't have much meaning to people who access  
9 the system on a daily basis.

10                   And some of you know I have a bias  
11 here. I am on the board of directors of FACT, the  
12 Foundation for Accountability, which is looking at  
13 how one can present a model of collecting quality  
14 information that would allow each and every consumer  
15 the ability to have meaningful information to compare  
16 plans and providers and others.

17                   And I would really like to see us  
18 strike out a little further in this paper, maybe not  
19 necessarily using that model, but the importance now  
20 in saying that information needs to be meaningful to  
21 consumers, not just to the regulatory agencies or the  
22 purchasing groups that are -- that a very basic model  
23 that already I know HICFA is talking about adopting  
24 this consumer friendly areas and collecting data and  
25 information, and I'd be happy to share that with you  
26 so that we can sort of look to see -- and I think  
27 along the areas of cost and access as well if I might  
28 just say in terms of cost. I don't really know who's

1 right anymore about whether costs are up or down.  
2 But I do know that when we talk with the public, they  
3 believe that they are paying more. And whether  
4 that's real or not, it's a perception that's very,  
5 very strong.

6 CHAIRMAN ENTHOVEN: I think what's  
7 going on there is there are data that show employers  
8 are one way or another making employees participate  
9 more in the premium.

10 There is, unfortunately, a kind of  
11 optical illusion because every economist will tell  
12 you that so-called employer paid health insurance  
13 really comes out as wages. But as it appears to the  
14 ordinary employee, and we've seen this in various  
15 ways: For example, the legislature limited the  
16 maximum contribution that would be made on behalf of  
17 state employees, University of California adopted a  
18 policy that they would only pay for the low priced  
19 HMO; Stanford did something comparable, et cetera.  
20 And so, it is true that people are -- that's where  
21 you get that. And I'm not sure what to say about it  
22 because it's --

23 MS. SEVERONI: One recommendation that  
24 I sometimes talk to employers about is why not  
25 quarterly or twice a year include in an employee's  
26 pay stub what the contribution is, what you're  
27 putting forth in terms of paying for their health  
28 care benefit so that I can sort of compare. But I

1 guess, sort of looking for some more practical ways  
2 to bringing some of that cost information back.

3 CHAIRMAN ENTHOVEN: You know that plow  
4 where them throw the USC -- they also throw the book  
5 with the -- forget that.

6 MS. FINBERG: Well, going back to our  
7 charge of the legislation about answering the  
8 question about whether the goals are met on quality,  
9 access and cost. That tells me -- I mean, this  
10 paper, I guess, is written as a background and  
11 basically saying yes, so voting on this paper,  
12 approving it, seems like it is a simplified answer.  
13 If we're going to expand this paper, which I think is  
14 difficult to do with these brevity suggestions, but  
15 if we're going to --

16 DR. ROMERO: Actually, Jeanne, just let  
17 me interrupt. That's strictly a format issue. You  
18 can have a lengthy paper and have a brief executive  
19 summary and you can separate them.

20 MS. FINBERG: Okay. That sounds good.  
21 Then to the extent that they're answering those  
22 questions, I'd like to see the questions answered  
23 from the consumer perspective and Ellen's comments  
24 goes to one part of it, the cost issue. The cost for  
25 the individual consumer is going up or, you know,  
26 other ways in which it has gone down.

27 And the same with regard to quality and  
28 the same with regard to access. Some of the most

1 difficult issues on access haven't been addressed.  
2 One would be the uninsured which we're giving very  
3 short-term treatment in our Task Force, but it needs  
4 to be mentioned. And the other access issues with  
5 regard to navigating the managed-care arena are very  
6 important issues that need to be addressed. And I'm  
7 guessing now that it needs to be in this paper so I  
8 would like to see that.

9 CHAIRMAN ENTHOVEN: Okay. Thank you.  
10 I think we're going to need now to move onto members  
11 of the public. Again, I want to ask you to make your  
12 comments very brief and concise and just to address  
13 this paper and to speak for no more than three  
14 minutes.

15 We'll start with Mr. Richard Van Horn,  
16 California Coalition for Mental Health.

17 MR. VAN HORN: This is the one I  
18 planned to be here for. I will not read the written  
19 testimony to you. But I do want to underline a few  
20 things in relation to this.

21 This year the mental health community  
22 had a bill caught up in the managed care bill net and  
23 with a threatened veto until this Task Force had made  
24 its report. So I need to ask you for some very  
25 special cooperation with us in this. We made this  
26 two-year bill to void the promised veto to cover any  
27 and all managed-care bills.

28 The argument for parity in a managed

1 system is the issue here. This was bill AB 1100 by  
2 Assemblywoman Helen Thompson, sponsored originally by  
3 the California Alliance for the Mentally Ill, the  
4 families group, and endorsed, of course, by the  
5 entire constituency.

6                   The letter of testimony underlined  
7 several points. Obviously, we wish to eliminate  
8 disparity in access and require all the health plans  
9 to eliminate specifically limitations on the  
10 availability of mental health care.

11                   This is the same recommendation and  
12 there's two pieces coming around to you that is in  
13 the Federal Employee's Health Benefit Plan annual  
14 call letter. The purpose of a call letter is to  
15 outline the requirements that are going to be there  
16 in any bids to be a provider under FEHBP. This call  
17 letter which is also coming around to you calls for  
18 parity and notes that it is not a legal requirement  
19 at this point. Federally, only lifetime and annual  
20 caps are -- cannot be discriminatory but the FEHBP  
21 call letter makes the point that they feel that the  
22 intent of legislation concerning the desire of the  
23 public is to have parity and that, properly managed,  
24 it would be, it will be, cost neutral. Seven states  
25 have already put into practice parity legislation and  
26 have found that it is, indeed, cost neutral when  
27 responsibly managed.

28                   The issue for us, which is key in this,

1 is that need to develop a flexible benefits structure  
2 offering a wide array of community services for the  
3 usual 20 outpatient visits 30 hospital days within a  
4 year. One of the things which we have found in  
5 development integrated care --

6 CHAIRMAN ENTHOVEN: Can you wrap it up,  
7 please.

8 MR. VAN HORN: -- is that hospital care  
9 to reduce from the standard 42 percent in Los Angeles  
10 County in particular to 6 percent in an adequately  
11 integrated system of care.

12 So we firmly, sincerely, heartfeltly  
13 urge that AB 1100 somewhere gets into your  
14 recommendations. Thank you.

15 CHAIRMAN ENTHOVEN: Thank you. We'll  
16 next hear from Mariana Lamb of the Medical Oncology  
17 Association of Southern California. Ms. Lamb, thank  
18 you for coming.

19 MS. LAMB: Thank you for allowing me to  
20 participate. Just a few things. Again, I'm the  
21 director of the Medical Oncology Association of  
22 Southern California. We meet quarterly with Medicare  
23 intermediaries, TransAmerica, Dr. Gerald Roben from  
24 NHIC. We also discuss policy issues with Dr. George  
25 Wilson from the Department of Health Services.

26 The concerns I have are with regard to  
27 the brevity of this most important aspect of  
28 health-care delivery, that's quality, cost and access

1 to care.

2 In terms of the concern I have with  
3 regard to quality of the care. How do you define  
4 quality? I know in oncology and in cancer care they  
5 define quality as outcomes, as response rate, and as  
6 you all know besides cardiology and diabetes, cancer  
7 is the third highest and most costly of all three  
8 currently on the rise in the United States.

9 Obviously we are affected completely  
10 different than the other patients that you currently  
11 are considering. I want to again caution on the  
12 shortness and the brevity in your paper.

13 One point on page 4, "Summary of  
14 Managed Care." The difference between Palm Springs  
15 prostate techniques and Stockton prostate techniques,  
16 strictly I would venture to say it is a population  
17 demographic issue. The concern of trying to make it  
18 brief and getting your point across, you lose the  
19 focus and you really lose the intent of why these  
20 things take place.

21 New treatments, obviously in cancer  
22 there's a new drug out every day, thank God for  
23 COBRA.

24 Going back to formularies, I believe  
25 the gentleman from the San Bernardino IPAs indicated  
26 that, yeah, a lot of formularies are based on  
27 kickback and rebates, creates concern in your  
28 recommendation for formularies that there is a basis

1 for this a scientific rational and not monetary  
2 kickback.

3                   Scientific justification, once again,  
4 we found that policies are devised more as an  
5 exception rather than based upon 2 percent fraudulent  
6 physicians. The 98 percent of physicians that  
7 actually prescribe this medicine and provide  
8 good-quality health care are scientifically based.  
9 And to broadly paint over physicians premise by  
10 indicating with no scientific justification, I have  
11 great concern over.

12                   Again, keeping factual and informative  
13 is my greatest concern. Thank you.

14                   CHAIRMAN ENTHOVEN: Thank you very  
15 much.

16                   We'll take about a 15 or 20 minute  
17 break so the members can get their lunch, but what I  
18 would like to encourage you to do is bring it back to  
19 the table. Let the court reporter change her paper  
20 and we will be working through lunchtime.

21                   (Recess.)

22                   CHAIRMAN ENTHOVEN: Would the members  
23 please take your seats as quickly as possible.

24                   Without objection could we move to the  
25 agenda item III-E which is the paper called "Risk  
26 Adjustment: A Cure for Adverse Selection."

27                   MS. FINBERG: Did we skip a paper,  
28 Alain?

1                   CHAIRMAN ENTHOVEN: I said without  
2   objection could we move to the agenda III-D.

3                   MR. LEE: It's "E" Risk Adjustment.

4                   CHAIRMAN ENTHOVEN: Item III-E which is  
5   the paper called "Risk Adjustment: A Cure for  
6   Adverse Selection."

7                   MS. FINBERG: I didn't hear that, I'm  
8   sorry.

9                   CHAIRMAN ENTHOVEN: May I just say  
10   briefly to launch this. There are a variety of  
11   reasons that people do or don't adopt risk  
12   adjustments and a variety of considerations from  
13   fairly pragmatic and short-term oriented to very  
14   fundamental and philosophical. I try to just briefly  
15   touch the ends of that spectrum, for example, adopted  
16   risk adjustment because they wanted to keep the  
17   wide-access products, PPOs for example, in their  
18   product mix.

19                   And what tends to happen in these  
20   multiple choice situations is if you offer people a  
21   choice between a more restricted access product and a  
22   wider-access product, let's say closed-end HMO versus  
23   PPOs, then the wider-access product tends to get  
24   adverse selection and the wider-access product tends  
25   to get spiraled, into a premium spiral because the  
26   playing field is not level.

27                   So one reason for adopting risk  
28   adjustment is to level the playing field and let

1 consumers have a fair economic choice of a  
2 wide-access product where they're paying for its  
3 higher costs because of weaker cost controls whether  
4 paying for the adverse selection motive. That's one  
5 reason.

6 But the other reason if you want to  
7 think broadly and philosophically, I think one of the  
8 reasons that we're having this Task Force and all  
9 these problems is because there is a lot of  
10 controversy over the morale foundations of the  
11 health-care system as it is presently constituted.  
12 And there are a number of issues that are of great  
13 concern to people. There are people on both sides of  
14 the issues. One we've been hearing a great deal  
15 about is the appropriateness of for-profit  
16 organizations in health care. I'm not taking a stand  
17 on this one way or another, I'm just saying that's  
18 one issue.

19 Another issue in the morale foundations  
20 of our system is concerns over fairness, if large  
21 numbers of people are left out of it, and another one  
22 is this whole problem of skimming -- and managed-care  
23 entities or any kind of health insurance, managed  
24 care or not, is often suspected of doing and creating  
25 skimming activities.

26 Sara and I were driving up the  
27 peninsula the other day and noticed a large Health  
28 Net billboard which said, "Well, Well, Well." And

1 healthy young people on the billboard and we recalled  
2 what we were all kind of commenting about in a  
3 discussion is that, well, no, we've got this right  
4 when there's a billboard that says sick, sick, sick.  
5 We do great work with AIDS and cancer patients.

6                   So I think with the lack of risk  
7 adjustment, which is function of the payers by the  
8 way and not the health plans, primarily is that we're  
9 putting health plans under an awful lot of pressure  
10 to find ways not to be terrific at taking care of  
11 very sick intensive people and that would be one of  
12 the ways of correcting a problem in which you could  
13 say the presently constitution is morally suspect.

14                   So I'll just -- with that before you  
15 see what does the Task Force think about adverse  
16 selection.

17                   I'll plead guilty to the fact that the  
18 paper is -- comes out in favor of it. We'll be  
19 considering recommendations in voting on the whole  
20 thing in the next meeting. So I guess the main thing  
21 now is just to consider the paper.

22                   Steve Zatkan.

23                   MR. ZATKIN: Alain, because I have to  
24 leave soon I do want to comment. I support the crux  
25 of this paper which is to encourage risk adjustment.  
26 I do believe it is an important and often overlooked  
27 element that can create a better system.

28                   In terms of the specifics under

1 recommendations I had, I think, in general, what they  
2 call for -- what they do is encourage, which I think  
3 is the appropriate route to take.

4                   One exception is the recommendation  
5 regarding any subsequent small group purchasing  
6 arrangements where they propose a requirement and I'm  
7 not sure that that is consistent with the general  
8 philosophy of the other recommendations which  
9 encourage and then say let's look if this hasn't been  
10 done within a certain period, then maybe a  
11 requirement would be in order. And I think that that  
12 philosophy should be consistent even as it applies to  
13 the small group arrangements which probably have a  
14 little bit more difficulty, frankly, in doing this  
15 because of the lack of staff and so on. So I would  
16 recommend that you consider a redraft making that  
17 more consistent.

18                   But I do support the thrust of the --  
19 of the paper.

20                   CHAIRMAN ENTHOVEN: Thank you. I think  
21 perhaps what we should say is first encouraged to do  
22 it and if that hasn't happened within three years,  
23 then the legislature should consider requiring it.  
24 And for those small groups that should come later,  
25 after the big. Most resourceful entities have done  
26 it. Because they'll get all the systems into place  
27 and it would be a lot easier for others to follow.  
28 So that will be the sense of it.

1                   MR. ZATKIN: I guess the other point I  
2 want to make: We talk about encouraging the plans to  
3 do this, as well, which I think is important. With  
4 respect to medical groups, did you look at the issue  
5 around hospitals, specifically, because that issue  
6 was raised. And I don't know enough about the  
7 technology to know whether that is appropriate or  
8 not. That certainly was the nature of the request  
9 that we got.

10                  DR. KARPFF: Could you clarify what  
11 you're asking?

12                  MR. ZATKIN: Whether technology around  
13 risk adjusting for the hospitals as opposed to  
14 medical groups is there, the technology is there and  
15 the acceptance is there.

16                  CHAIRMAN ENTHOVEN: I think the  
17 technology is there for global, you know, for  
18 capitation for comprehensive services. One problem  
19 is that typically or frequently health plans don't  
20 capitate hospitals. There are some exceptions to  
21 that. And so they're usually being negotiated all  
22 inclusive per diems. So, in a sense, you could say  
23 that more is paid for the hospitals who do more.

24                  MR. ZATKIN: So when we heard from the  
25 academic medical centers, we were hearing more in  
26 terms medical services they provide rather than  
27 hospitals.

28                  DR. KARPFF: No, I don't think that's

1 correct. I think it's a combination of both. I  
2 think there is some technology available to risk  
3 adjust patients within a hospital or among hospitals.  
4 Like when we take a look at what we have to report to  
5 a variety of entities we end up always risk  
6 adjusting. If we don't, there's a very skewed view.

7               As an example, we were responding to a  
8 HICFA center of excellence who took a look at our  
9 mortality at UCLA. In a raw fashion our mortality is  
10 very high. If you look at mortalities in a  
11 risk-adjusted fashion, mortalities were actually  
12 better than expected. So I think the methodology  
13 isn't perfect, sort of in a nascent state, but I  
14 think it needs to be development. I think risk  
15 adjustment based strictly on capitation will help  
16 some, but not totally alleviate all the issues. I  
17 think there's sort of a combination between risk  
18 adjustment and recognition of centers of excellence,  
19 and not on a case by case basis, but a smaller than  
20 capitated basis that needs to be at some point in  
21 time recognized.

22               CHAIRMAN ENTHOVEN: Peter.

23               MR. LEE: This is, as I understand it,  
24 different than the last two papers. This is not a  
25 background paper. Even though this came from staff  
26 this is where we're starting to make recommendations  
27 to improve things.

28               I think what might be helpful, there

1 were five and a half, I think, specific  
2 recommendations here. Are there comments on  
3 recommendation one, or in some way a structure going  
4 through this and I appreciate this across the board.  
5 I've got different comments on different things.  
6 That's just a process suggestion on substance.

7                   Again, I think we need to be very clear  
8 who we're making recommendations to and when we're  
9 making advisory recommendations and when we're making  
10 specific recommendations.

11                   I read this somewhat differently than  
12 Steve and it seems to me that three of these maybe  
13 are requests for legislation. Maybe not today, maybe  
14 tomorrow, but we need to be very explicit, I think,  
15 as a task force, to say we are advising the plans or  
16 someone, this is a good thing to do such as I think  
17 when I call recommendations three and four, the ones  
18 at DHS versus the other recommendations which all  
19 have requirement elements. And when I read a  
20 requirement element, I interpret that to mean the  
21 legislature should or someone that can make someone  
22 do something should do it. And if we're making a  
23 recommendation, which in many places this is, now  
24 we've started us down a much longer path where we're  
25 saying "requirement," I think we need to be explicit  
26 and say who we're saying should be doing this  
27 requirement.

28                   So that's the sort of introductory

1 notes. With that, do people think it would be useful  
2 to go through each recommendation at a time or should  
3 we state all our comments on all five or six?

4 CHAIRMAN ENTHOVEN: Ron, are you going  
5 to speak to that?

6 MR. WILLIAMS: Yeah, if I may.

7 I think that -- I think it might be  
8 useful to have a general discussion on the front end  
9 for a portion of the time about some of the  
10 philosophical issues and then move into some of the  
11 specific comments and I have general comments I would  
12 like to make if I could do it now.

13 CHAIRMAN ENTHOVEN: Be sure to speak  
14 into the mike.

15 What you're saying is let's first  
16 discuss the broad philosophical strategic aspect and  
17 then halfway through our hour we'll come back and  
18 walk through the specifics one at a time?

19 MR. WILLIAMS: Yes.

20 MR. LEE: I think that's a great  
21 process suggestion. With that I'll make one overall  
22 comment besides that if I could.

23 I think this is one of the most  
24 important areas where we can encourage and try to  
25 highlight and I appreciate that this is the first  
26 area we're making recommendations in into the current  
27 flow. And I think it is also one of the ones  
28 generally where requirements are probably least

1 appropriate, there are some appropriate ones. But I  
2 think it's great to highlight this area as we are  
3 doing.

4 CHAIRMAN ENTHOVEN: I think, Peter, on  
5 the requiring issue --

6 MR. LEE: That's a specific  
7 recommendation, Al.

8 CHAIRMAN ENTHOVEN: We'll get that,  
9 yeah. Now let's see where are we. Now if I can go  
10 back to my order here, Alpert and then Griffiths.

11 DR. ALPERT: I applaud this. This  
12 address to this recommendation I think the theme is  
13 terrific. First of all, it does one of the things  
14 that's been important to me, in a simplistic fashion,  
15 and that is to identify the issues that are so  
16 paradoxical and we can all agree they shouldn't be  
17 happening and it's actually stated here. And when it  
18 talks about a survival strategy for a group that  
19 would be good to actually avoid developing excellence  
20 and that's true whether you're a physician or for a  
21 hospital or medical group or whatever you are, and  
22 this addresses correcting that paradox that we can  
23 all agree.

24 It does invoke, as the chairman has  
25 said, the morale imperative, which is wonderful, and  
26 I recommend for everybody to read and I concur. And  
27 so I applaud the theme and the great issue of this  
28 and there have been a couple -- oh, and to comment on

1 one of the things that already has happened that Dr.  
2 Karpf was asking about and I assume that to be -- I  
3 interpret that as the multi-tiered use of the risk  
4 adjust. And that's actually an executive summary is  
5 -- looks to me to be spelled out quite clearly,  
6 should further require risk adjustment payments flow  
7 through to medical groups and other providers and  
8 hospitals and providers and so forth. So to me it's  
9 included here.

10 I've got a couple other specific things  
11 but I'll save those.

12 CHAIRMAN ENTHOVEN: Okay. Thank you.  
13 Diane.

14 MS. GRIFFITHS: I wanted to raise an  
15 issue that we didn't discuss. I believe it was part  
16 of the presentation on risk adjustment papers and  
17 that's the issue of patient's privacy concerns around  
18 the information sharing that would be required to  
19 risk adjust.

20 And I haven't had any opportunity to  
21 really dialogue with people about that, nor do any  
22 research. But clearly, in an environment where  
23 people are discriminated against based on health  
24 status, both in terms of insurance purchase and in  
25 terms of employment, broader sharing of medical data  
26 concerning patients can be problematic for people.  
27 And maybe my question would be addressed to the  
28 consumer representatives here. This paper assumes

1   that the cost benefit analysis for consumers comes  
2   out in favor of risk adjusting premiums. That is  
3   that broader access and lower cost insurance is a  
4   greater value than maintaining the privacy concerning  
5   your medical records or, alternatively, that there  
6   will be sufficient protections involved in risk  
7   adjustment that they will not be harmed by it. More  
8   of a philosophical question, but not one that we've  
9   discussed previously.

10                   CHAIRMAN ENTHOVEN: I believe the  
11   technical methods are available so that when the  
12   health plan transfers the data to the central  
13   clearing house to do it, that the patient records are  
14   re-coded in such a way that it's not possible to  
15   identify individual patients and I think OSHPD does  
16   that, the HIPIC -- now I haven't really gone into  
17   technical details which talk about how data we have  
18   gotten to analyze is made publicly available in such  
19   a way that you can't identify these.

20                   MS. GRIFFITHS: Just a follow-up  
21   question on that: I am aware that there are  
22   scrambling techniques to delink identity from  
23   diagnosis, et cetera.

24                   But what happens when the patient  
25   changes from PacifiCare to Kaiser? There's no --  
26   we're not envisioning an incremental kind of risk  
27   adjustment but some other more general form that  
28   will -- wouldn't require the transmission of that

1 data that you're getting a healthy patient not  
2 getting a sick patient?

3 CHAIRMAN ENTHOVEN: That would be a  
4 different question. Usually the way this is done is  
5 for 1997 we have the data from different health  
6 plans, you know, with the appropriate scrambling, and  
7 then the clearing house does the econometric modeling  
8 to translate that into financial and that is used as  
9 a predictor for the following year.

10 MS. GRIFFITHS: So it's analyzed?

11 CHAIRMAN ENTHOVEN: Right. That would  
12 be an interesting and worthwhile thing to do to find  
13 a convenient way that the patient can authorize the  
14 transfer of her medical records from Kaiser to  
15 PacifiCare or vice versa.

16 MS. GRIFFITHS: Or not.

17 CHAIRMAN ENTHOVEN: Or not, uh-huh.  
18 That authorized means you have a choice.

19 MS. GRIFFITHS: Right.

20 CHAIRMAN ENTHOVEN: Jeanne Finberg.

21 MS. FINBERG: Unfortunately I'm going  
22 to have to go so I'm not going to be around for the  
23 full discussion of recommendations but I would like  
24 to say that I do really like the paper, background  
25 and analysis. It doesn't suffer from a lot of the  
26 problems that we were concerned about before in terms  
27 of spin or lack of balance, et cetera.

28 One question I did have, though, in the

1 first part of the paper, which comes up with regard  
2 to the recommendations with regard to HICFA and  
3 Medi-Cal, I am unclear as to what initiatives are out  
4 there on those areas of risk adjustment. I thought  
5 there were some and that's not reflected, so that  
6 might be an area that could be developed and  
7 explained before we make recommendations in that  
8 area. With that I'm going to leave. Thank you.

9 CHAIRMAN ENTHOVEN: Where is Medi-Cal?  
10 We'll get into that. Thank you.

11 Bruce Spurlock.

12 DR. SPURLOCK: Thank you, Mr. Chairman.  
13 I just want to expand a little bit on what Dr. Karpf  
14 said in a little bit technical, but I think there's a  
15 piece missing here and this is my general statement.

16 I think that one of the recommendations  
17 we need to think about is to push technology forward.  
18 It's a very technical recommendation and I think that  
19 when you look at large populations, which most of the  
20 risk adjustment models look at health plan level,  
21 it's different than looking -- potentially different  
22 than looking at the level of the hospital, level of  
23 the physician of a medical group and to the extent  
24 that the model is different, we need to know that and  
25 understand that because what's really important is to  
26 pass it through those to front line levels so that  
27 the populations that the model, this so-called black  
28 box that you know we put numbers in it for that, and

1 then understand the difference for each population.

2 We talked a little bit about this with  
3 Gaucher's disease and other populations that don't do  
4 well as long as we don't have that level of risk  
5 adjustment technology.

6 So I think a recommendation needs to be  
7 added to the extent that we need to encourage further  
8 research in this area about different populations and  
9 analyzing how different they are in risk adjustment  
10 technology versus general populations.

11 CHAIRMAN ENTHOVEN: Very good. All  
12 right.

13 Getting back to Peter's question, what  
14 do you think specifically -- well we can be making a  
15 statement to foundations. Medicare has been -- I  
16 mean HICFA has been putting a lot of money into this  
17 research. We want to say implementing it does not  
18 mean stop research, continue, the more the better.  
19 Right. Okay.

20 Northway.

21 DR. NORTHWAY: I just want to follow a  
22 little of what Diane Griffiths said or maybe  
23 something a little different.

24 I presume that when we are talking in  
25 this particular area we're talking about a  
26 relationship between plan and the provider and in the  
27 consumer or members side, a member is a member is a  
28 member is a member regardless of what the member's

1 basic health background, and that once we determine  
2 that a patient or a member has a bad health record,  
3 then the added costs are not transmitted back to the  
4 patient who happens to have picked up the wrong  
5 health care problem. The issue here we're really  
6 talking about is the relationship between the plan  
7 who has already received the money and the providers  
8 to make sure the providers who are taking care of  
9 sick patients don't get run out of business, is that  
10 right?

11 CHAIRMAN ENTHOVEN: That's the idea.

12 DR. NORTHWAY: Also to follow up on  
13 what Kim said, I think, at least on the Medi-Cal side  
14 and the pediatric side, that a lot of the high-risk  
15 patients have been carved out because they're still  
16 in the CCS carve-out which is not part of the  
17 Medi-Cal managed-care program, but there may be some  
18 pilots out there in which she's going to look at how  
19 these patients do interact.

20 CHAIRMAN ENTHOVEN: Kim, do you want to  
21 comment on that?

22 MS. BELSHE: I think Dr. Northway  
23 touched on this.

24 MR. WILLIAMS: A few comments: One is  
25 I think this is a very good concept, it's very  
26 desirable. One of the things I'm concerned about,  
27 though, is it's a concept that needs further  
28 exploration, further pursuit. The actions that we

1 take, the actions we recommend, need to be in sync  
2 with the actual level of capability to apply a  
3 methodology to this.

4 I recall in some of the testimony in  
5 the last meeting some of the articles I've read which  
6 clearly demonstrate the ability to apply this to a  
7 Medicare risk population or a population over 65.

8 In consultation with our actuaries,  
9 they suggest that there are substantial differences  
10 in applying this to a commercial population. Some of  
11 those problems are really data problems as opposed to  
12 problems of will or problems of desirability. It  
13 focuses on the whole question of coding, the whole  
14 question of transient populations where the employer  
15 moves and you have lots of turnover perhaps during  
16 the year, you've got downsizing, you've got upsizing.  
17 So I think we need to find the concept with a real  
18 research base.

19 There are a couple of things I would  
20 recommend staff take a look at. One of which I will  
21 make available is a study by the American Society of  
22 Actuaries which is an extensive look at risk  
23 adjustment and reaches conclusions that have to do  
24 more with the data methodology and some of the  
25 constraints around that and I will share that.

26 And I also recently heard of a study by  
27 the group health -- a purchasing group in  
28 Massachusetts which is essentially kind of like our

1 CalPERS and I understand they had a study conducted  
2 by Coopers and Lybrand. To the extent we can get  
3 access to that I think it can give us a bit of  
4 additional fact base.

5 I think there's also a couple of other  
6 points. One is the whole question of how we manage  
7 to process, focusing not just on the HMO population  
8 but also when you talk about managed care we again  
9 have to broaden the number of categories we're  
10 talking about because we do have the PPOs, we have  
11 the fee-for-service segment that goes outside of the  
12 PPOs and this.

13 I would also encourage us not to forget  
14 the opportunity to use other techniques like stop  
15 walks, enrollment protection. I think the reference  
16 made to Medi-Cal is a very good example of how high  
17 risk situations are outside of the capitation  
18 experience and people are capitating for things that  
19 are much more routine, much more predictable and they  
20 are different.

21 I think the final comment, which is one  
22 I struggle with, is the question of: How does this  
23 go from the health plan down to the medical groups?  
24 And because the medical group and the hospital  
25 situations are negotiated arrangements, I assure you  
26 that every medical group that believes that its  
27 population is sicker and needs an adjustment will be  
28 more than glad to receive that adjustment.

1                   On the other hand, every medical group  
2 who believes it is due for an increase will fight  
3 tooth and nail to maintain its current level of  
4 reimbursement. So the whole question is it's the  
5 right thing to do, but we'll end up with some  
6 inflationary results on it. I don't have an answer  
7 but I think in terms of really understanding the  
8 implications.

9                   So kind of just to summarize, I think  
10 we need to really understand the difference between  
11 the Medicare population and the commercial  
12 population. We need to really understand the data  
13 limitations in terms of coding and methodology and we  
14 need to look for examples that demonstrate we're not  
15 doing research on ourselves but that we feel that the  
16 state of the technology is sufficient that we can  
17 safely proceed to the exploration of the concept.

18                  In the interim again we might look at  
19 stop loss and enrollment protections techniques. And  
20 I would also encourage us to talk to actuaries in  
21 addition to the health economists that have  
22 presented, that the actuaries also have done a great  
23 deal of research in this area.

24                  CHAIRMAN ENTHOVEN: Thank you.

25                  MR. WILLIAMS: A fairly important issue  
26 which is our preferred method of contracting would be  
27 to capitate for fairly predictable events and to  
28 provide stop loss protection at a fairly low level so

1 that the medical group is insulated. The big tension  
2 we get is that the medical group typically wants to  
3 assume all of the risks in a capitated environment  
4 and there's a whole host of reasons on which other  
5 people can comment. But there is increasing pressure  
6 in the HMO to assume as much of the capitation  
7 responsibility as they can, and we have lots of  
8 debates about that with them. Again today, it's the  
9 negotiation, and if you want access to that group you  
10 tend to find a way to work through that in a  
11 cooperative way. We do make use of stop losses in  
12 varying levels and different groups, but when we  
13 contract we make use of all techniques not just one.

14 DR. KARPFF: I can't leave that totally  
15 unanswered, Ron. I think that certainly stop loss  
16 has been a very important mechanism of ameliorating  
17 or modifying the modalities, but I think your firm as  
18 well as other payers, are actually shying away from  
19 that process, and the contract we're negotiating with  
20 Blue Cross at this point in time -- we're very  
21 complex patients across the board and Blue Cross has  
22 refused to keep its stop loss provision in. So I  
23 think that that has a possibility of ameliorating the  
24 process, it's certainly not an answer. And payers,  
25 as they're starting to feel the pressure for cost  
26 containment and for profits, don't necessarily view  
27 that as a public good.

28 CHAIRMAN ENTHOVEN: I certainly agree

1 with your ideas about the need of stop loss as one of  
2 the tools of risk adjustment -- the idea was not to  
3 suggest that risk adjustment be the whole story.

4                   You take something like Gaucher's  
5 disease -- I don't know where PERS is on this  
6 today -- but clearly the logical thing for them to do  
7 is to figure out what is the broad incident of  
8 Gaucher's disease and take that back from the health  
9 plans and say we'll pay for that directly because  
10 it's such a costly thing. One of the problems in the  
11 econometric research on this is you get good  
12 predictors for groups of patients like A's, type B's,  
13 and so forth way out on the ends of the tables of the  
14 statistical distribution that you don't get very good  
15 predictions and kind of they're using stop loss for  
16 extraordinarily high cases or costly cases.

17                   Not only that, consolidating the  
18 purchasing power is probably a good idea. Asking  
19 every health plan to go out and negotiate for  
20 Gaucher's providers is probably not economic. So  
21 I'll make sure that we put something in.

22                   MR. WILLIAMS: I think one other point  
23 is in response to Michael's comment. I won't go into  
24 negotiations here, but I think we do believe very  
25 much in case rates. I guess another approach is  
26 global case rates for transplantation and other types  
27 of high-risk procedures where you enter into an  
28 arrangement for the transplantation, for all the

1 services that are necessary, and that there's one  
2 rate and it's not a question of how much is this  
3 going to cost. Again, it's carved out.

4 CHAIRMAN ENTHOVEN: Rebecca.

5 MS. BOWNE: Ron has stated very  
6 eloquently some of the points that I was going to  
7 make but in my usual fashion I think I'll make a few  
8 more and I'm sorry that Jeanne has left because I do  
9 not find this to be a balanced paper at all.

10 I would have to say, at the outset,  
11 that I think that risk adjustment, when the  
12 methodology is available, will be very, very helpful  
13 and in some limited fashion they are starting to get  
14 that. And I know that it sounds like the panacea and  
15 the end all, but in blunt terms it's taking money out  
16 of one pocket and putting money in the other pocket.  
17 That's what a risk adjustment is. And when you go  
18 about that kind of thing, you have to be reasonably  
19 careful that your actuarial basis for doing such a  
20 task is on very sound footing. And I would certainly  
21 question in this paper whether the experiment limited  
22 with the HIPIC over a very small population base is  
23 adequate.

24 Now, I'm not saying put your head in  
25 the sand, don't do it. I think that we need to very,  
26 very definitely, and the federal government through  
27 Medicare risk contracting is -- has stated in the  
28 balance budget amendments that they will be working

1 on more accurate risk adjustment. But let's reflect  
2 back a little bit to the whole business of insurance  
3 and the spreading of risks. In the opening of this  
4 particular paper it talks about payers paying  
5 university health plans the same premium for caring  
6 for healthy young or patients seriously ill.

7                   However, what has happened is that a  
8 whole history of actuarial science through experience  
9 base has determined what the overall premium to that  
10 employer will be and then that is divided equally  
11 among a number of participants.

12                   And fortunately we have recent federal  
13 legislation that says you'll ensure the whole group  
14 and take all of the dependents within the whole group  
15 which eliminates much of the, one can call it cherry  
16 picking if one chooses to, as well as we have small  
17 group reform legislation to curb the majority of  
18 abuses that certainly have gone on and the industry  
19 has needed to clean up and we've needed a government  
20 hand to help us clean up.

21                   But I would suggest to you that this  
22 paper implies far more sophistication than is  
23 currently available for risk adjustment and it  
24 absolutely frightens me to the core of my being,  
25 Alain, for to you say we will encourage it for three  
26 years and then if it's not done, we'll put it in  
27 government mandate form because I would suggest back  
28 to you that the science is not there yet, that we

1 need to be recommending it with all due speed and, of  
2 course, we put effort and initiatives into this, that  
3 is, where we can, where it's applicable we apply it.  
4 But I think, to say the least, this is jumping the  
5 gun above and beyond what may be practical at this  
6 stage of the game and that's not saying stop where  
7 we're going, let's go there faster. But recognize  
8 we're not there yet because in the end you will be  
9 saying to a risk-adjustment mechanism, and I'll put  
10 it in this way so that you will all be offended,  
11 "Take money away from Dr. Karpf's hospital and put  
12 money in Dr. Northway's hospital."

13 DR. NORTHWAY: Good idea.

14 MS. BOWNE: So while this sounds good,  
15 I would caution and put great caution on you. Let's  
16 deal with the actuarial science first, and encourage  
17 that to be dealt with with all due speed, and take on  
18 experiments and calculate those and, in fact, even  
19 reallocate payments where we think it's appropriate.  
20 But before you're ready to say everybody do it and  
21 let's legislate it, I say let's get the facts.

22 CHAIRMAN ENTHOVEN: This is not saying  
23 everybody do it. This is saying PERS which is  
24 looking at it hard and is on the verge of doing it  
25 anyway. This is to give them a little extra  
26 encouragement. I think we need to reword some of the  
27 rest of it. After that, when it's up and working on  
28 a large scale, then it should be further rolled out.

1 It's not saying everybody do it today. I wouldn't  
2 agree with that.

3 Michael.

4 DR. KARPFF: I do think that technology  
5 must improve risk adjustment. We look at a system  
6 that looks at patient demographics, percent  
7 hypertensive, percent diabetes, that's probably not  
8 going to work.

9 When Professor Luft spoke to us he said  
10 that he was experimenting with preimposed diagnosis  
11 for risk adjustment which may, in fact, put dollars  
12 credited towards patients that have substantive  
13 diseases that need those dollars credited. I don't  
14 know where that methodology is right now, but I think  
15 it needs to be encouraged and I think we need to put  
16 some type of effort and concern on it.

17 I have some concern with the  
18 recommendations and the disadvantage and the  
19 advantage of not having had the opportunity to read  
20 these reports. But many of the comments I heard this  
21 morning were really reflected towards specifics that  
22 were made in the report as opposed to trying to  
23 define principles. You're making specifics here and  
24 telling PERS to do it, you're telling DHS to do it,  
25 you're telling someone else to do it. You may come  
26 up with four or five different modalities of risk  
27 adjustment. I'm not sure that that's necessarily the  
28 best approach, but maybe what we should be doing is

1 recognizing the principle that we must do risk  
2 adjustment and mandate that the state, over some  
3 period of time, come up with a mechanism that is  
4 California-based, that essentially gets some bias in,  
5 but at least has the opportunity of enforcement on a  
6 more uniform basis.

7                   So I personally very much support risk  
8 adjustment. It will be one of the issues that I  
9 speak to when I speak to the needs of academic health  
10 centers and how you preserve some very nationally  
11 important entities. But I'm not sure that we can get  
12 down to the specifics of who does it at this point in  
13 time. It needs to be done. It needs to be  
14 supported, the technology needs to be developed.  
15 Let's not say who does it, let's just make sure it  
16 gets done, and make sure it gets done in a uniform  
17 kind of way so we don't have five or six different  
18 systems that we're arguing about.

19                   CHAIRMAN ENTHOVEN: Somebody has to be  
20 the penguin off the iceberg and into the water. And  
21 the PERS seems like the next logical step and it's  
22 under state control.

23                   MR. LEE: If I could, we talked about  
24 it half an hour maybe just going into specific  
25 suggestions and that's sort of responding to that and  
26 there's a lot of people in line. I don't know if we  
27 want to keep going to general suggestions or toward  
28 trying to get to the concrete ideas.

1                   CHAIRMAN ENTHOVEN:   Okay.

2                   Michael Shapiro, you're next on the

3   list.

4                   MR. SHAPIRO:   This paper struck me as

5   coming in like a lion and going out like a lamb.

6                   I was convinced of the importance of

7   doing something about risk adjustment, particularly

8   because of the collective action problem of waiting

9   for someone to make a move.   It hasn't happened

10   absent some government program or some government

11   intervention.

12                  I was also struck on page 4 of the

13   report by the heading on C:   "The Time is Now for

14   Risk Adjustment."   I mean, it seems to me you can

15   wait for a perfect system, you can wait for perfect

16   information, you can wait for perfect methodology,

17   you can wait forever.

18                  I think you also -- this goes back to

19   what Peter was saying, we have to be clear as to what

20   we're recommending.   Are we recommending to the

21   legislature to do nothing and to encourage it or

22   watch it and come back and revisit in three years?

23   This task Force may not be around.   I think you have

24   to understand the window of opportunity of what it is

25   you want to recommend the governor and legislature do

26   next year.   What is it they can do to make something

27   happen now?

28                  If you take an example like CalPERS,

1    which I endorse, you can do a lot and actually that  
2    gives them three years to get it off the ground  
3    themselves and then act with some force.  You can  
4    also say the legislature comes back in three years.  
5    Those are two very different recommendations.

6                    You can build in time and resources and  
7    expertise to do the best possible job within a  
8    reasonable time with some certainly for the players  
9    that they're going to have to do something.  Or you  
10   can say, you know, let's encourage this and let's job  
11   own it.  But if you have lack of concerted action,  
12   lack of resources, and lack of mandate, then three  
13   years from now you're back potentially to where you  
14   started saying no one took us up on this offer and we  
15   have to mandate it.

16                   So if, in fact, there is general  
17   consensus that risk adjustment is a serious problem,  
18   and I tend to think it is in terms of the vulnerable  
19   populations, then I think you might want to do the  
20   most meaningful actions, forcing recommendations that  
21   are qualified and restrained by virtue of some of the  
22   concerns that were raised as opposed to  
23   recommendations that just say this is really  
24   important, we're not ready yet, don't do anything.  I  
25   think you can hopefully accomplish your goals and  
26   mitigate your concerns in the context of something  
27   that you've mandated so you have some likely  
28   expectation that there will be progress and success

1   tempered by additional methodology studies. But I  
2   would counsel that, in fact, this is an important  
3   goal you should seek to obtain as best you can.  
4   Simply quality it rather than for go recommendation.

5                   CHAIRMAN ENTHOVEN: Thank you.

6                   Attorney Hartshorn.

7                   MR. HARTSHORN: I can say a lot less  
8   now after hearing people make presentations that I  
9   generally support this, I support what Ron said and  
10  the last comments and I think we need to start to  
11  start and I hope we don't come up with a  
12  recommendation that looks at studying or something.  
13  I think we need to encourage at the beginning because  
14  that will encourage the development of the technology  
15  as well.

16                   One thing we need to be careful of, if  
17  I missed it I apologize, we need to make sure that I  
18  think it's been implied, I think it's neutral to the  
19  consumer as possible or is neutral. Because if we  
20  start at CalPERS and they're going to pass it down to  
21  a risk-adjusted premium or something down to plans  
22  would pass it onto the providers, it has to -- it  
23  can't impact the individual. I think the study  
24  that -- or the process you talked about, Alain, that  
25  it would be an annualized process, I think that needs  
26  to be, you know, carefully looked at because you can  
27  have some fairly major shifts of populations in time  
28  amongst health plans. It's still the same employer,

1 but the employer may drop the health plan or drop a  
2 couple and add some new ones and you can get some big  
3 shifts, so just make sure that there's some  
4 appropriateness as those shifts take place and not be  
5 a year or two lag.

6 CHAIRMAN ENTHOVEN: Okay.

7 Ms. O'Sullivan.

8 MS. O'SULLIVAN: Very exciting. Seems  
9 like for years these discussions people were saying  
10 we just have to adjust the rates and pass that  
11 problem, so it's exciting to hear that the technology  
12 is getting there.

13 I don't see anything in here that talks  
14 about small purchaser and I see a lot of danger with  
15 small purchasers because then you're really getting  
16 down to, you know, you've got an AIDS employee,  
17 therefore your rate goes up, and I assume we don't  
18 want that to happen so.

19 CHAIRMAN ENTHOVEN: Well, ideally what  
20 you would like is to have all the small purchasers  
21 and large HIPIC like pools even larger than the HIPIC  
22 we have now, at which point they would be able to do  
23 this as the HIPIC is doing.

24 MS. O'SULLIVAN: So maybe we want  
25 something in here that acknowledges that?

26 MR. LEE: I think that sort of is,  
27 recommendation four does just that. Purchasing  
28 groups must do risk adjustment.

1 MS. O'SULLIVAN: What I'm looking for  
2 is if purchasing groups don't and there are still  
3 small employers out there negotiating on their own to  
4 make sure they're protected. Right? We don't have  
5 to do that?

6 MR. WILLIAMS: You can't bury small  
7 group rates within a certain range.

8 CHAIRMAN ENTHOVEN: Just apply it to  
9 large entities. We would apply this to large  
10 entities.

11 MS. O'SULLIVAN: And then the  
12 confidentiality questions I think would be much more  
13 tense as a small purchaser level also.

14 On page 2 Dr. Toldmeal is talking  
15 before the early '90s adverse selection was not a  
16 serious problem. And I sure remember talking a lot  
17 about dividing up and cherry picking and skimming and  
18 so I just didn't get that.

19 CHAIRMAN ENTHOVEN: Well, I was  
20 thinking of that from the point of view of the impact  
21 on providers because before the '90s employer  
22 payments tended to be open ended which is, you know,  
23 here's the fee-for-service plan and we'll pay it, and  
24 so this problem didn't rattle through to providers.  
25 But I think that that's not well worded.

26 MS. O'SULLIVAN: And maybe this isn't  
27 the time to say it, but I just want to go with what  
28 Mark was saying about when we get to the

1 recommendation section I'm afraid when we say let's  
2 wait for three years and see if somebody does it,  
3 that this really is more than we just say there's a  
4 good idea out there folks, let's hope somebody does.

5 I hear you're saying you think PERS is  
6 going to do it anyway, but I think we ought to be  
7 working to make a difference.

8 CHAIRMAN ENTHOVEN: Here's one of the  
9 problems with PERS. This is how frustrating it is to  
10 make any progress in this crazy world. The way that  
11 the employer contribution works in PERS now is a  
12 maximum it's set by law like \$175 per employee per  
13 month. And it turns out that now, this is perfectly  
14 true or approximately true I'm not sure which, that  
15 all the HMOs are below that maximum meaning the  
16 employer pays in full and so there is no premium  
17 price sensitivity.

18 Above the maximum are the PPOs, so  
19 people have to pay out-of-pocket for the PPOs. If  
20 you do risk adjustment, the likely consequence based  
21 on the experience of the HIPIC and what's happening  
22 to those employers is you will add a small surcharge  
23 to the premiums of the HMOs and then a substantial  
24 subsidy to bring down the price of the PPOs. And  
25 since the -- that will benefit the employees who are  
26 paying for the PPOs. The PPOs will now cost them  
27 less and the state will be paying for the extra  
28 premiums of the HMOs.

1 MS. O'SULLIVAN: I'm sorry, I didn't  
2 get why that happened.

3 CHAIRMAN ENTHOVEN: Because the state  
4 pays your premium in full up to \$175 per month. And  
5 so if you raise Kaiser's premium from \$150 to \$152,  
6 the state is going to play that, not the employee.  
7 So the concern is that will cost the state some  
8 money. So there is reluctance to do it for that  
9 reason.

10 MS. WHITAKER: I work with the  
11 Department of Personnel Administration and I've been  
12 intimately involved with PERS on the risk adjustment  
13 and, Dr. Enthoven, you referred to putting a penguin  
14 on ice. The approach that PERS is currently using to  
15 risk-adjusted premium is putting the penguin on ice  
16 with roller-skates.

17 I like the idea of risk adjustment. I  
18 said that last month when the lady from MRMIB was  
19 here. I think there's a lot of merit to risk  
20 adjustment, especially by diagnosis. Unfortunately  
21 that's not the way PERS is going. They've been  
22 working with a consulting firm Watson and Wyatt who  
23 has looked at risk-adjustment premiums, they talked  
24 about diagnosis related premium risk adjustment.  
25 The RFP that went out asked for risk adjustment  
26 information, however it's based on age and sex only.

27 The primary motivation is that they  
28 want to save the PERS Care plan. It costs too much,

1 people can't afford it, and the concept is to add a  
2 surcharge to the lower-cost plans to pay to the PERS  
3 Care plan.

4 As a state employer we have a problem  
5 with that, first of all because as you say it sends  
6 up the premiums of all the HMO plans without really  
7 looking at whether or not PERS Care has a higher  
8 number of people with health conditions that cost  
9 more.

10 In addition, the HMO plans were  
11 standardized several years ago. PERS Care has never  
12 been standardized and we don't know how much of the  
13 difference in premium is based on risk versus  
14 delivery, you know the method of delivery. And we  
15 ain't there yet. And I get nervous when I see things  
16 like this that you're going to want PERS to do this  
17 because they don't have any clue as to what you're  
18 talking about at this point.

19 CHAIRMAN ENTHOVEN: I don't think  
20 that's true.

21 THE PUBLIC: I don't want to get sued  
22 but they may, but that's not where they're going.  
23 Their board is not going that way.

24 CHAIRMAN ENTHOVEN: I suggest you talk  
25 with Margaret Stanley, she is extremely knowledgable.  
26 So I wouldn't suggest that she doesn't know what  
27 she's talking about.

28 THE PUBLIC: I don't think that's the

1 case. I think there's more than risk adjustment  
2 going on there. I think the primary concern is to  
3 save PERS Care.

4 CHAIRMAN ENTHOVEN: I mentioned at the  
5 outset that there's a lot of reasons from the mundane  
6 to the philosophical for why people do this. And I  
7 did mention with HIPIC that's why they did it to save  
8 their wide-access product. I don't think that's an  
9 illegitimate motivation, I think that's a reasonable  
10 one to create a level of playing field so that the  
11 people who want the wide-access product pay for the  
12 extra amount that goes with the inefficiency of their  
13 delivery system, but they don't pay for the extra  
14 amount that goes with that selection. So that's a  
15 legitimate goal, but there is the real problem that  
16 will cost the state money. And I'll have to confess  
17 I don't have an estimate of how much it will cost the  
18 state, that's kind of embarrassing, I guess, I  
19 shouldn't make the recommendation without some idea  
20 of knowing.

21 MS. O'SULLIVAN: Is it a one time cost,  
22 is that what it is because you've got to be giving so  
23 much to the extra.

24 CHAIRMAN ENTHOVEN: As long as the  
25 present system of employer contribution is in place.

26 Now, what the state is trying to do  
27 what Mayor Lee is trying to negotiate with the unions  
28 is a new basis of payment which would be to aggregate

1 up a bunch of fringe benefits into a package and put  
2 the price tag on that and say you have a flex plan,  
3 you can shop among all these things and take your  
4 pick, and if you choose a less costly HMO, you can  
5 put more in your dependent care or your dental care  
6 or something like that which would then make the  
7 state's liability finite and would mean that the  
8 people choosing the HMOs that are now getting  
9 favorable selection would be having to pay  
10 appropriately more for that.

11 MR. LEE: Time flag, we're a little  
12 over our 45 minutes.

13 CHAIRMAN ENTHOVEN: Tony Rodgers.

14 MR. RODGERS: I look on risk adjustment  
15 as a driver and I look on what we're talking about  
16 here is things to dampen the systems behavior versus  
17 to drive the systems behavior. Certainly risk  
18 adjustment is a driver. Talking to Cal Optima and  
19 other organizations that deal with vulnerable  
20 populations, this is a key strategy because what they  
21 want to do is certify their networks and without --  
22 and I think it's going to be in our recommendation  
23 without the ability to offer some risk adjustment it  
24 is difficult to get specialized providers to  
25 participate and certainly to certify them that they  
26 can really handle the population that they're  
27 probably being assigned. And I think that came  
28 across with AIDS patient who say they're being

1 assigned to providers who don't know how to take care  
2 of AIDS.

3 So this is a linked driver. So as you  
4 think about this there are a couple things in the  
5 vulnerable population area that are dependent on us  
6 moving either with this or a different strategy that  
7 will keep the specialized numbers in place.

8 CHAIRMAN ENTHOVEN: Okay. Peter Lee.

9 MR. LEE: I was going to hopefully move  
10 to some of the specific recommendation discussions.  
11 Is that --

12 MR. ZATKIN: Peter, if I could just  
13 interrupt for just a second. Just on general  
14 philosophy. I try to keep track of where the Task  
15 Force has reasonably brought agreement and this is,  
16 frankly, the first I've heard. So I just want to  
17 check my perceptions.

18 Before we get into specifics I just  
19 want to get a sense, does most -- well, do Task Force  
20 members believe that it should be possible to fashion  
21 a set of recommendations that they can endorse or is  
22 there anybody who does not believe that?

23 That was my hopeful inference. Thank  
24 you. Okay, Peter.

25 MR. LEE: Thank you. The first is --  
26 and this is -- and I think for all the areas we get  
27 into there is going to be areas that are consensus  
28 areas pretty quick that I'd like us to do and move on

1 and talk about the harder issues that are required or  
2 not required.

3 And one that I heard here is that I'm  
4 looking now at the bottom of the first page of the  
5 executive summary where it says; "when appropriate,"  
6 et cetera, et cetera. I think the first  
7 recommendation is an advisory recommendation which is  
8 major purchasers and foundations should support the  
9 development of et cetera, et cetera. And that's a  
10 recommendation that I certainly hear everyone here  
11 strongly agreeing with and I agree with Michael's  
12 point that certain things that you make as  
13 recommendation carry different weight. But I think  
14 that's very important for us to have the first thing,  
15 this needs to be developed, the science needs to be  
16 moved along, and I would move that hopefully by  
17 consensus.

18 DR. KARPFF: In a reasonable time frame.

19 MR. LEE: In a reasonable time frame so  
20 that it's a priority issue for major purchasers and  
21 major foundations to fund and support these.

22 MR. WILLIAMS: Where are you?

23 MR. LEE: I'm at the very bottom of  
24 what isn't a bullet on the first page of the  
25 executive summary. Instead of saying "when  
26 appropriate," I deleted when appropriate and said  
27 something along the line major purchasers and  
28 foundations should support the development of

1 appropriate analysis to, et cetera.

2                   It's to -- I'm not doing the words  
3 specifically right now, Ron, but that the agreed  
4 recommendation that I've heard is that it should move  
5 ahead in a studied way with all deliberate speed and  
6 that speed should be fast. So I think that's a  
7 starting recommendation.

8                   The next -- these of bullets moved up  
9 to the first recommendation on the PERS which should  
10 be bounced around and I would -- I mean, this is -- I  
11 would love this discussion because I've learned  
12 something and I'm a little bit more cautious than I  
13 would be on some requirement areas, but at the same  
14 time I think having no mandate is dangerous. The  
15 mandate that I would like to see for CalPERS is  
16 that -- is -- the legislature call on CalPERS to  
17 report to it in "X" period, whether it's two years  
18 from now we say a date, what is done to implement  
19 risk adjustment and why or why not. And then  
20 it's -- the mandate is CalPERS as a major purchaser  
21 that the legislature can call on has to make the case  
22 why it hasn't moved on the area the legislature views  
23 as particularly important. And that's an amendment  
24 of -- it's not saying required by "X" years, but by  
25 two years from now CalPERS do a report. So that's a  
26 proposed amendment to recommendation one.

27                   MS. BOWNE: So in effect whether, how,  
28 and why or why not they move on risk adjustment.

1 MR. LEE: Yes.

2 CHAIRMAN ENTHOVEN: Can I just get a  
3 show of hands.

4 MS. O'SULLIVAN: Can I comment on it.  
5 I think it's very weak. I think that what CalPERS  
6 can then do is hold their head up high and come back  
7 in three years and say we didn't do it, the  
8 technology is not there.

9 MR. LEE: But part of just -- as much  
10 as one of the things that -- I mean, I think risk  
11 adjustment is absolutely one of the most important  
12 things. But risk adjustment done wrong hurts people  
13 who are most vulnerable and I don't want risk  
14 adjustment that is going to penalize providers of HIV  
15 care, because risk adjustment done wrong would have  
16 them getting under compensated.

17 CHAIRMAN ENTHOVEN: Of course, Peter,  
18 that's what we have today.

19 MS. O'SULLIVAN: It's not going to do  
20 anything but help people who are working with the  
21 sickest patients.

22 CHAIRMAN ENTHOVEN: There's no way it's  
23 going to hurt HIV/AIDS providers. There may be some  
24 argument about when the adjustment factor ought to be  
25 8 or 12 or something.

26 MR. LEE: I somewhat disagree because  
27 one of the issues of this topic probably shouldn't be  
28 called risk adjustment, the answer, it's the need to

1 avoid risk avoidance. And one of the things  
2 mentioned is carve outs, there's a number of specific  
3 things that can be done to avoid risk avoidance and  
4 for example in Medi-Cal my understanding there's a  
5 number of pilot programs that have specifically  
6 capitated-based service provisions for people with  
7 AIDS and HIV. If someone thinks, oh, let's stop  
8 doing that because now we've got risk adjustments,  
9 instead we'll pay providers 7 percent more, I mean,  
10 there are way in terms of looking at how this could  
11 happen that could negatively impact vulnerable  
12 populations.

13 CHAIRMAN ENTHOVEN: Well, I agree with  
14 Ron that we should indicate there's a broader range  
15 of tools which are appropriate, this is one of them.

16 Let's see where are we now. Okay.

17 MR. RODGERS: Yes. I was just curious  
18 because of the impact that Medi-Cal is having on  
19 academic medical centers that get a lot of risks is  
20 it appropriate to include SDHS and as they move  
21 populations into managed care to look at risk  
22 adjusting for those populations they are going to do  
23 it for the AIDS population, that is a proposal that  
24 they are considering now. So would that be another  
25 group that we want to include in this recommendation?

26 MR. LEE: You know, I suggest that  
27 looking around the room I think we're all looking at  
28 somewhat different pages. We could be looking at the

1 executive summary which is in one order or we could  
2 be looking at the back of page 5 which is a  
3 different order. I suggest we're looking at  
4 different pages. Help us to be as they say to be all  
5 on the same page. Al, if I could suggest I suggest  
6 look at page 5 because that's a more full description  
7 of each of the things that is on the executive  
8 summary.

9 MS. SKUBIK: In terms of the  
10 recommendations in the executive summary.

11 MR. LEE: They shouldn't be different  
12 though.

13 MS. SKUBIK: This is an issue of race  
14 to go get papers out the door.

15 MS. SINGER: I would recommend looking  
16 at the executive summary because that was the thing  
17 that we worked on last.

18 MR. LEE: Okay.

19 CHAIRMAN ENTHOVEN: The third item  
20 there is for DHS to seek to join with HICFA in a  
21 cooperative project to explore risk adjustment for  
22 payments to managed-care plans serving Medi-Cal  
23 beneficiaries and that risk adjusted payments flow  
24 through appropriately to providers.

25 MR. RODGERS: Okay. Thank you.

26 CHAIRMAN ENTHOVEN: Now, you know one  
27 could make it stronger. I wish Kim were here to  
28 comment.

1 MS. SKUBIK: I just tried to bring her  
2 in but she's working on a crisis on legislation with  
3 the governor's office right now. If you have a -- is  
4 there something that you wanted to change there?  
5 CHAIRMAN ENTHOVEN: No. Just find out  
6 if she was uncomfortable.  
7 MS. SKUBIK: She's fine with this  
8 executive summary.  
9 MR. LEE: I think that No. 3  
10 recommendation at least needs to say instead of  
11 explore expand because this is happening.  
12 MS. SKUBIK: How about to further  
13 explore. I mean that's --  
14 MS. O'SULLIVAN: If I wanted to  
15 strengthen that recommendation I would say that the  
16 legislature should require DHS to reach out to HICFA  
17 to do da, da, da, da, da.  
18 MS. BOWNE: Why does this have to go  
19 back through the legislature? I think we all know  
20 with all due respect to our legislature that they're  
21 not always successful.  
22 DR. ROMERO: Nothing personal.  
23 MS. SKUBIK: We think you should do  
24 this.  
25 MS. BOWNE: This is coming from a  
26 governor's recommendation to one of his own  
27 departments.  
28 MS. O'SULLIVAN: No, it's not. This is

1 a Task Force recommendation.

2 MS. BOWNE: Whatever.

3 MS. O'SULLIVAN: We could say the  
4 governor should instruct or the legislature should  
5 require. One or the other. Just for us to say DHS  
6 should do it shouldn't --

7 MR. LEE: And on bullet three, I think  
8 it is important to build in and report to the  
9 legislature the status of those efforts by "X" date.  
10 I mean it's -- if we all recognize this is such and  
11 important issue we want to keep it in front of the  
12 legislature and one of the ways to do that is to  
13 report back on what DHS, this is with relation to  
14 No. 3, has done.

15 CHAIRMAN ENTHOVEN: Maryann, we're  
16 going to get to issues later on where the  
17 recommendation is going to be the governor should  
18 direct his department to do the following, like  
19 direct the regulatory agency to streamline and  
20 simplify.

21 MS. O'SULLIVAN: I'm just saying the  
22 governor or the legislator has to make somebody do  
23 it.

24 MR. HARTSHORN: On No. 3, I'm on the  
25 executive summary now for Medicare and Medicaid, I  
26 would go back to whoever made the suggestion to  
27 expand the risk adjustment because right now Medicare  
28 does pay based on age and whether or not people are

1 institutionalized, so it's a beginning point. So we  
2 want to expand past this.

3 CHAIRMAN ENTHOVEN: That's right. Very  
4 good. Medicare has for 20 years had a risk  
5 adjustment-payment system and the problem is that it  
6 just didn't include diagnosis. So, right.

7 Helen.

8 DR. RODRIGUEZ-TRIAS: I wonder if we  
9 could include some addition language to make  
10 recommendation in terms of the monitoring of it and  
11 the actual effect on the outcomes indicators in the  
12 vulnerable populations because I think that's  
13 something that we're going to want to be looking at  
14 as well as the effects on whoever the costs and  
15 everything else.

16 CHAIRMAN ENTHOVEN: Well, that is going  
17 to be into our paper, I think, measuring and  
18 monitoring -- identifying, measuring and monitoring.

19 DR. RODRIGUEZ-TRIAS: Right. It may,  
20 but I think specifically talking to the risk  
21 adjustment and as risk adjustment progresses that  
22 that be one of the criteria that's applied.

23 CHAIRMAN ENTHOVEN: Okay.

24 Martin Gallegos.

25 HONORABLE GALLEGOS: No.

26 MR. SHAPIRO: I wanted to go back to  
27 PERS alternative and a study and report back by  
28 CalPERS without any obligation to move the system

1 forward.

2                   What I would urge consideration of is  
3 the original recommendation with a three-year  
4 mandate, with a two-year report back by CalPERS where  
5 they can be forgiven not going forward at some point.  
6 But I'm worried about any type of study or  
7 recommendation for reports without some obligation to  
8 pursue that in good faith the best process and within  
9 two years which is a long time they cannot come up  
10 with something that they're willing to implement  
11 because of concerns like Peter's seems to me you the  
12 option to come back to the legislature and extend  
13 that date or remove it.

14                   But if you don't start with your  
15 recommendation that we have a reasonably application  
16 to do reasonably good work in three years, in two  
17 years tell us to help you out, you're back to just  
18 this, it's another study Task Force on this issue.

19                   So I think, again, there's ways of  
20 mitigating the concern of not having enough  
21 information without eliminating one of the few  
22 requirements that are recommended to deal with this  
23 area. So I would urge consideration of retaining the  
24 three-year obligation with a two-year report back to  
25 allow for reconsideration at that time.

26                   MR. LEE: I would take that as a  
27 friendly amendment to my language on No. 1 and noted  
28 without in terms of the timing, we are at the one

1 hour mark but we haven't talked about four of the  
2 recommendations so I would encourage us to focus on  
3 reaching closure on recommendation one and then going  
4 specifically through each of the recommendations  
5 similarly to see straw pole or whatever so staff have  
6 information to rework so when it comes back next time  
7 it's ready for a vote.

8 I understand the friendly amendment,  
9 CalPERS -- the legislature direct CalPERS to, one,  
10 issue a report on -- really the first thing is to  
11 implement risk adjustment in three years.

12 However, it is also directed to in two  
13 years issue a report that would explain status of its  
14 efforts to do that. And in the event it thinks that  
15 it is not feasible, why or why not so the legislature  
16 can consider extending the three-year mark. But the  
17 three-year mark is a hard date. The two-year mark is  
18 where they need to report to the legislature on  
19 progress and status of their efforts and the status  
20 of the size and why they have or haven't moved  
21 forward.

22 MS. BOWNE: And does this relate to  
23 CalPERS or PBGH.

24 MR. LEE: This relates to CalPERS  
25 because I think the legislature would have good luck  
26 telling PBGH what to do. But I think the thing that  
27 still stays parenthetical, I think CalPERS in  
28 parentheses preferably in accommodation with PBGH.

1 But the legislature should encourage CalPERS to work  
2 in cooperation with other large purchasers. So that  
3 PBGH we're not trying to pretend we're telling what  
4 to do.

5 MR. WILLIAMS: Peter, if I may. The  
6 one issue that hasn't been addressed is the cost  
7 issue. I just want to say for the record that we are  
8 not in CalPERS. So I'm speaking with no interest one  
9 way or another financially in this.

10 That it -- we need an action forcing  
11 event. That I agree with 100 percent. But we also  
12 need to do no harm. Whenever there's a solution like  
13 this sometimes I joke that in documents we should say  
14 magic occurs here because we really don't know what  
15 the methodology and process is. And yet we need to  
16 encourage people to go figure out what it is and we  
17 also need to make certain that no harm is done in  
18 this process.

19 And somehow I'm struggling with the  
20 balance of how do we push people in the right  
21 direction and how do we make sure there's no harm and  
22 something about cost control or that basically says  
23 figure it out and this is the threshold of the  
24 problem if that's the threshold.

25 CHAIRMAN ENTHOVEN: The two-year report  
26 could do that. To come back to the legislature and  
27 say we just discovered this will cost the state \$10  
28 billion. And then the legislature can reconsider. I

1 mean, in principle it's supposed to be cost neutral.

2 MS. SEVERONI: A comment and believe me  
3 you can shoot me because I'm going to take us right  
4 off the recommendations to say that if I were the  
5 governor or the legislature, I think I would feel a  
6 lot more compelled to act aggressively, which is what  
7 I think we want here. If we were to start by talking  
8 about the problem and this paper starts by talking  
9 about the solution, risk adjustment, it doesn't start  
10 by talking about what the problem is adverse  
11 selection and avoidance and why those things are  
12 really hurting everyone.

13 So I'd like to see us sort of turn this  
14 up on its head a little bit and start with that  
15 problem. I know you'd get on a little bit.

16 CHAIRMAN ENTHOVEN: The text starts on  
17 page 2, the text with: "Today, payers, employers  
18 almost universally pay health plans the same premium  
19 for caring for a healthy young adult and for a  
20 patient with serious, costly chronic conditions."

21 MS. SEVERONI: But we're looking at the  
22 executive summary. So that I think it's got to start  
23 there and also I think that we need get to sort of  
24 cardinal burning ends again when we come to the moral  
25 high grounds which I think is one of the compelling  
26 reasons we're all coming together around this is some  
27 of the morale statements that he's making about  
28 what's wrong with the system as it's set up today.

1                   And I think we can find that people  
2 might be able to get to recommendations more directly  
3 if we could adopt a few principles around which we  
4 all agree and then recommendation structures  
5 mechanisms following from that.

6                   So as we go back to reworking this  
7 paper I think we have a better discussions and it  
8 would be easier to make recommendations if we were  
9 all sure of the principles we agreed upon.

10                  MS. BOWNE: But you know in the  
11 recommendation, and I agree with your concepts,  
12 Ellen, I think we also need to recognize be careful  
13 when we talk about past, present and future.

14                  We've just had federal laws passed that  
15 said small group carriers must guarantee issue to all  
16 small groups within rates that are determined by each  
17 state.

18                  And in large groups you must guarantee  
19 issue to all individuals and their dependents within  
20 the group. Now hopefully that should mitigate. I'm  
21 not saying that's all, we need to push ahead on risk  
22 adjustment, but I think it would be appropriate to  
23 recognize that that action has taken place and  
24 perhaps needs to be monitored for its implications.

25                  MR. LEE: To move us -- I mean, I think  
26 Ellen's comments are well taken and encourage  
27 everyone to write other suggestions back in the draft  
28 after they get back to staff.

1                   One that I really like is your  
2 billboard analogy which was brought up, that's a  
3 great introduction because we like to see billboards  
4 with people in wheelchairs and that's what this is  
5 about.

6                   Is there some way we can call the  
7 question on recommendation as suggested to see -- to  
8 not hear an objection but then move on No. 2. We  
9 talked about a straw vote so we don't want people to  
10 be surprised next time. So this is what's going to  
11 coming back. I didn't try to wordsmith it as I --

12                  CHAIRMAN ENTHOVEN: I've taken notes on  
13 the wordsmithing but the legislature calling CalPERS  
14 to implement within three and report within two.

15                  MR. LEE: And I think adding some of  
16 Ron's notes about that report should include, you  
17 know, why, why not, cost implication and others  
18 certainly would be friendly, additional wording.

19                  MR. WILLIAMS: I guess the question I  
20 was asking is whether or not it's appropriate for  
21 cost neutral to be one critical criteria.

22                  MR. LEE: I would suggest not. It says  
23 "cost be a critical factor." But not necessarily  
24 cost neutral, there's a benefit of doing it -- if  
25 it's a point "X" percent increase might outweigh. So  
26 personally I would have trouble saying it would have  
27 to be cost neutral, but considering cost absolutely.

28                  CHAIRMAN ENTHOVEN: Okay. Any other

1     comments on recommendation one?   Great.

2                     On two I think I want to offer a  
3     friendly amendment on No. 2 and that is we want to  
4     bring in the idea that we don't want to ask or press  
5     the other purchasing groups to do this until the big  
6     ones have done this because they have the resources  
7     to, in effect, require, compel the data system should  
8     be in place.

9                     So it's like PERS, preferably with  
10    other major purchasers, would get all the health  
11    plans to get all the data that would be needed and  
12    would be running the system.  Then it would be much  
13    easier for others.  So I think we ought to word it to  
14    reflect that.

15                    MR. LEE:  Suggestive wording.  If we  
16    have a two-year calendar mark is to have the  
17    legislature appropriating committees consider in two  
18    years mandating for help new purchasing groups risk  
19    adjustment or carve out or other mechanisms for this.

20                    But to request they calendar it as  
21    opposed to saying they do it today.

22                    MS. BOWNE:  Are we speaking about the  
23    second bullet point here about greater spread of pool  
24    purchasing agreements?

25                    MR. LEE:  The next sentence where it  
26    says there's a requirement element:  "Any new  
27    purchasing group shall be required to risk adjust."

28                    MS. BOWNE:  I would take objection

1 to -- and I know, Alain, this is near and dear to  
2 your heart, but I think there are other ways of  
3 getting insurance other than through large purchasing  
4 pools and this seems to imply that that's the only  
5 and best way.

6 CHAIRMAN ENTHOVEN: It's the only way  
7 of getting competition among managed-care plans in  
8 the small group market. But I've had long talks with  
9 Ron Williams and with his boss who feel that Blue  
10 Cross would be delighted to do the whole job  
11 themselves.

12 I think that's wonderful except that  
13 there's a little problem and that is we want  
14 competition on a level playing field and with --  
15 another paper we're going to be bringing along after  
16 a while is to do with consumer choice of health plan.

17 MR. LEE: What additional  
18 recommendation would you make to show -- are you  
19 saying that you want to see risk adjustment  
20 encouraged among other arrangements as well, or you  
21 don't want the Task Force to encourage the spread of  
22 purchasing pools. He's not sure.

23 MS. BOWNE: I don't want the Task Force  
24 to encourage the spread of pools as a sole mechanism  
25 which this implies.

26 CHAIRMAN ENTHOVEN: We'll have to take  
27 that. We're going to have a paper with our expert  
28 resource group on expanding the realm of consumer

1 choice.

2 MS. O'SULLIVAN: The comment that any  
3 new purchasing group should be required to risk  
4 adjustment, I'm back to the concern I raised earlier  
5 that some small purchasing group might be from an  
6 industry where there's, you know, a lot of people  
7 with AIDS and we don't want to, you know, drive their  
8 rates through the roof.

9 So I think there's got to be something  
10 about that. Any major purchasing groups. I don't  
11 know what the right thing is to say, but I'm worried  
12 about that.

13 CHAIRMAN ENTHOVEN: I get the sense of  
14 what you're trying to say. I agree with the sense of  
15 it. We don't want to burden them, so I'll work on  
16 words.

17 MR. LEE: Suggestion to address  
18 Rebecca's concern, there may be a more appropriate  
19 more extensive discussion about the role of pool  
20 purchasing arrangement. It probably is not in the  
21 discussion of risk arrangement.

22 MS. BOWNE: It doesn't belong in this  
23 paper.

24 MR. LEE: So I think this  
25 recommendation can just be shifted to action taken by  
26 the State of California to encourage appropriate risk  
27 adjustment amongst everyone, but including full  
28 purchasing arrangements.

1                   The requirement element here is what I  
2   was suggesting the legislature in two years review  
3   potentially mandating such arraignments. It's a  
4   calendar issue rather than say the legislature should  
5   do it today. That's what I would suggest. But if  
6   everyone take that working adjustment on the  
7   beginning, that case is done.

8                   DR. ROMERO: The chronological  
9   relationship would be that that calendar should come  
10   one, two, three years after the CalPERS deadline.

11                  MS. O'SULLIVAN: Right or after the  
12   report.

13                  DR. ROMERO: We obviously don't want to  
14   require for the private market before we want to  
15   require if for CalPERS.

16                  CHAIRMAN ENTHOVEN: The CalPERS project  
17   is pretty much completed. That is the data systems  
18   are working and they can keep up with the system.  
19   Okay.

20                  Any other comments on the fourth one?

21                  MR. LEE: The fourth one?

22                  CHAIRMAN ENTHOVEN: DHS participate in  
23   the HICFA sponsor --

24                  MS. BOWNE: That's the third one.

25                  MR. ROMERO: We just finished the  
26   second. The third is the expanded risk adjustment.  
27   The one thing I think we absolutely need to add in  
28   there risk adjustments carve outs or other mechanisms

1 just to reinforce that this is not a human  
2 dimensional vehicle.

3 CHAIRMAN ENTHOVEN: Right.

4 MR. HARTSHORN: And we should -- it  
5 says for Medi-Cal beneficiaries and Medicare  
6 beneficiaries.

7 MR. LEE: Absolutely.

8 CHAIRMAN ENTHOVEN: Any other comments  
9 on recommendation 3?

10 Then we move onto No. 4. Work with  
11 Medicare.

12 MR. LEE: Seems that this is  
13 either -- you're breaking No. 3 apart or its's  
14 redundant. So whenever -- it may be appropriate to  
15 break this to actually have a Medicare and Medi-Cal  
16 recommendation so I suggest we pull it out of three  
17 and move it down to four and have them separate.

18 MS. O'SULLIVAN: How come DHS is doing  
19 Medicare?

20 MR. LEE: There's many Medi's that's  
21 doing -- I think I suggested as part of the No. 3  
22 asking for a report to the legislature and I would  
23 suggest it be in two years on the status of those  
24 efforts.

25 And now that Kim's coming back in the  
26 room she'll be thrilled to be asked to do a new  
27 report.

28 MS. BELSHE: What have I been assigned

1 to do?

2 MR. LEE: Mandating reporting, but I  
3 would suggest that this is such an important issue  
4 where we aren't mandating it happen, we do need to  
5 keep it in front of the legislature and doing it to  
6 move the process along and one way of doing it is by  
7 reporting. Okay.

8 CHAIRMAN ENTHOVEN: All right.

9 MS. O'SULLIVAN: Where was that, Peter,  
10 the reporting?

11 MR. LEE: I add it -- I suggest it  
12 comes at the end of No. 3.

13 MS. O'SULLIVAN: Earlier there was a  
14 suggestion that there be a mandate.

15 Can I say when we discussed that we  
16 said -- first I said the legislator and somebody said  
17 the governor and I said either way. I want to say  
18 that I recommend that where we can that we emphasize  
19 moving it through the legislature because then you  
20 have a process that can be accountable, you got  
21 hearings, you can follow it. If you say to the  
22 governor we recommend you do this, the governor gets  
23 to just say no and then it's over.

24 DR. ROMERO: Then you can take up. If  
25 you're not satisfied with his inaction, then you can  
26 always take it up to legislation.

27 MS. O'SULLIVAN: That's true. But I  
28 would encourage that we at least always have both and

1 I would be in favor of the legislative process.  
2 HONORABLE GALLEGOS: That's true, Phil,  
3 that you certainly can go that route. However, if  
4 you know offhand that the governor doesn't want to  
5 act on that, then there may not be the desire on the  
6 part of the legislature to pick up the ball and carry  
7 it if there's a hostile feeling from the  
8 administration and the bill can become veto bait and  
9 then it's -- well, yeah, I mean, if the governor  
10 says, well, that's not an area that I really want to  
11 act on and you said then the legislature can pick up  
12 the ball and carry it, well, yeah, but they know it's  
13 dead on arrival even if the bill got through both  
14 houses and the legislature because the governor would  
15 have already telegraphed his intent on those.

16 689: I think this is a good example.  
17 There's intention here and I don't think I have a  
18 good solution to this. On the one hand, I agree with  
19 Peter's suggestion a minute ago, we want to be as  
20 specific as we can about who ought to do what because  
21 that's what health policy makers love.

22 On the other hand, few of us, certainly  
23 not me, are political experts and I'm just saying all  
24 the dynamics just illustrated by your example.  
25 The -- therefore I would like to be -- my  
26 recommendation would be that where there -- where we  
27 have alternatives we would love to list them both.  
28 You know, right now that's a little less clear than

1 Peter's, but it also means that we're not taking  
2 sides.

3 MR. SHAPIRO: I don't think it's  
4 important whether you tell the governor to do  
5 something or tell the legislature. I think what's  
6 important for the Task Force to make clear what you  
7 think should be required versus what you're  
8 encouraging because if the executive branch has the  
9 discretion to do it and we can see if they do it.

10 While we might not agree with them,  
11 let's put it in law. If there is no discretion, then  
12 you're going to need the legislation. But I think  
13 what's dangerous is when you encourage something and  
14 then either we introduce a bill and the governor says  
15 do it, and you say it wasn't a mandate that I had in  
16 mind.

17 So I think you need to be very clear  
18 this needs to be done now or in three years. This is  
19 not great, let's encourage it which means you're just  
20 going to let the market and hopefully the evolution  
21 process do it. I think let the governor decide how  
22 to deal with mandates that you're requesting in terms  
23 of whether new laws and regulations or order of  
24 executive branch.

25 I don't think you need to resolve that,  
26 but I think you need to be very clear and  
27 encouragement versus something you really want done  
28 as an legal matter.

1 DR. ROMERO: Can we summarize that as  
2 clarity is critical on the what.

3 MR. SHAPIRO: I think shall versus  
4 should.

5 MR. LEE: Beyond particular govern's  
6 terms, I think there's real value with having  
7 legislatures specifically charged with having to  
8 spell it out. I'm happy with just sticking with  
9 shalls.

10 MS. BERTE: Legislatures change too.

11 MR. LEE: They do, they do. We want  
12 our recommendation. I'd like to wrap this up, I  
13 think the last one is --

14 DR. SPURLOCK: I had some comments.

15 CHAIRMAN ENTHOVEN: On the last one?

16 DR. SPURLOCK: Yes. It's the biggy  
17 from my perspective.

18 I wanted to just make a couple of  
19 comments on the last recommendation and add some  
20 words and then throw something out on the table as  
21 far as the working.

22 I think we should take out the word  
23 "major" and leave the word "purchasers" in there and  
24 then include after risk adjustment tools, carve-outs,  
25 et cetera, so that if we have a whole spectrum of  
26 things so that people either by mandate or  
27 voluntarily or whatever, we don't categorize them as  
28 major purchasers, that they're just purchasers. And

1 then we want this to pass through to the folks who  
2 are actually providing the care so that risk  
3 adjustment process continues.

4 I also want to say that it's really  
5 required, really so broadly, and we should talk about  
6 one or two options.

7 One option that comes to mind is that  
8 we could say that these purchasers should require in  
9 their contractual relationships. Another option, and  
10 not necessarily a preferable option, we could say  
11 that the EOC or whatever oversight body should do  
12 this and report back in a year or two on the success  
13 or lack of success so that someone's actually  
14 watching this and forcing either the purchaser or the  
15 government oversight body because we need to make  
16 sure that this is happening and not just have the,  
17 you know, the negotiating process stop this because  
18 otherwise how are you going to pass on to -- how are  
19 you going to be sure that you're passing it on to the  
20 appropriate level of providers.

21 CHAIRMAN ENTHOVEN: I think that's  
22 reasonable, Bruce. I'm just having trouble figuring  
23 out in what year are we going to ask EOC to do it  
24 because it could be in year four or five.

25 DR. SPURLOCK: I guess I'm not as  
26 concerned because the Federal Balanced Budget Act had  
27 this suggested out in five years. So I think that we  
28 could do a five-year time frame, four- or five-year

1 time frame if we really wanted to.

2 But I think we do have to have some  
3 kind of mechanism to come back and revisit this issue  
4 at a time appropriate so that we know that it's  
5 happening.

6 CHAIRMAN ENTHOVEN: Well, five years,  
7 that ought to be comfortable.

8 MR. SHAPIRO: Just a quick comment,  
9 legal question. Is there an ERISA problem here? Are  
10 we telling purchasers -- first of all, is this a  
11 "should" or a "shall" and are you telling purchasers  
12 to do something? They don't have a contractual  
13 relationship with providers. It seems what we  
14 normally do is we have jurisdiction over plans, the  
15 plans are receiving risk-adjusted rates, it seems to  
16 direct the plans to in turn deal with their providers  
17 in a fair manner.

18 So how this recommendation is couched,  
19 who you direct to do what may be significant from a  
20 legal point of view as well as a regulatory point of  
21 view. It's not clear to me. Is this something the  
22 legislature were to propose legislation requiring  
23 health plans to pass down these risk-adjusted rates?  
24 Is that consistent or inconsistent with this  
25 recommendation? Is this a "should" or a "shall"?

26 MR. LEE: My comment on that also. As  
27 I read this one, I was unclear as I read it. And as  
28 I read at first is this is advisory to purchasers?

1 So as I read this, then I got another recommendation  
2 I would like to consider. All major purchasers are  
3 encouraged to require, as a matter of contract -- we  
4 can encourage folks to put whatever they want in  
5 their contracts, but that doesn't get, as Bruce has  
6 noted, where do you want this to fall. And if that's  
7 what this means, the question I want us to consider  
8 as an initial recommendation is to what extent should  
9 those health plans that get risk-adjusted payments be  
10 required to pass those along to medical groups or  
11 providers. And that's the required question that we  
12 could mandate whether it's through the EOC or  
13 whichever.

14 But I read this to be an encouragement,  
15 a matter of contract. Another recommendation I'd be  
16 interested in hearing people around the tables  
17 response to is to what extent the state mandate that  
18 where there are risk adjustments they don't just hit  
19 the plan level, they trickle down, and that's  
20 something I am very concerned about and maybe that's  
21 addressed in a report or mandate issue. But that's  
22 -- that's it.

23 MR. RODGERS: There's a technical  
24 question. If a plan is doing stop loss as a way of  
25 controlling risk, would you count that as meeting the  
26 requirement that they are protecting the provider in  
27 that regard or are we just talking about passing  
28 dollars? Because you could ask the plan to require

1   that they demonstrate how they do this and that opens  
2   it up for the plan then to go back to the regulatory  
3   agency and say, "This is how we do it and this is an  
4   improvement" versus saying, "You are required to  
5   pass dollars." Just a thought.

6                   CHAIRMAN ENTHOVEN: Ron Williams.

7                   MR. WILLIAMS: A few comments. The  
8   first one is it would be helpful, I think, if the  
9   sentence starts with once risk adjustment is proven  
10  to be technically feasible. Let's first start with  
11  the fact that it's been demonstrated to work.

12                  I think the other words that would be  
13  helpful would be consider adjusted payment increases  
14  and decreases because that's what we are talking  
15  about. And I think, again, I can't stress enough  
16  that my fear is the inflationary nature of this which  
17  is everyone wants the increases and no one wants the  
18  decrease, and what we end up with is substantial  
19  changes.

20                  I think the other thing that I don't  
21  know the answer to is that there are contractual  
22  arrangements between the health plans and the medical  
23  groups. And we are basically mandating in some way  
24  that the provider organization agree to contract  
25  terms that would come out of his profit.

26                  So I don't understand all the issues  
27  involved, but it seems like there are some  
28  contractual implications to this.

1                   CHAIRMAN ENTHOVEN: I don't think this  
2 Task Force is going to be able to work out all these  
3 details. But at some point I think we have to set a  
4 policy as some important first steps. The details I  
5 think are going to have -- we can't mastermind that  
6 from here.

7                   Alpert.

8                   DR. ALPERT: I just want to respond to  
9 Peter's question. If you don't pass it all the way  
10 through, then a paradox still exists. To me if you  
11 don't take step 1 at all, but step 2 is intrinsically  
12 linked to step 1 otherwise there will be a lot of  
13 money in the middle and everybody will be getting a  
14 billion dollars and you'll still have people not  
15 getting rewarded for care. So you either do both or  
16 don't do either, as far as I'm concerned.

17                  CHAIRMAN ENTHOVEN: Barbara Decker

18                  MS. DECKER: I do agree with the  
19 comment about requiring and what the obligation is  
20 and I think the most likely entities other than  
21 CalPERS to do this probably will be organizations  
22 that can't be governed by state law and the  
23 ERISA-type plans. And so I would recommend that we  
24 make this an advisory "should," include it in their  
25 contracts. I think that's great.

26                  And I also like the idea that we not  
27 restrict it. I second Tony's comment that this is a  
28 good thing of saying let's encourage each plan to

1 find ways to no longer shift the risk but to  
2 appropriately find ways to accommodate and make sure  
3 providers are receiving appropriate economic  
4 compensation for the risks they are assuming. And so  
5 having here in the state the plans that are regulated  
6 by state agencies have to report how they are  
7 addressing this issue, I think is a reasonable  
8 request on our part and a suggestion -- let's see,  
9 I'd say we should recommend that the regulatory  
10 agencies require that the plans as part of that are  
11 reporting to indicate how they're addressing this,  
12 not prescribing that they must do it one way or  
13 another, but demonstrate what they're doing to  
14 address the issue.

15 CHAIRMAN ENTHOVEN: Mark, and then I  
16 think I'd like us to wrap this up, it's been a great  
17 discussion.

18 MR. HIEPLER: It's right on as far as  
19 the difference between IPA models and a group model.  
20 And the goal is to get that to the actual physician  
21 who is having to see the patient over and over again.  
22 And whether you allow, as Tony's variety suggests,  
23 some greater form way to do it or actually require a  
24 raise to every primary care physician, I think that  
25 should be demonstrated that it's actually helping the  
26 doctor in the trenches who is seeing the sick patient  
27 as opposed to staying at the IPA level and never  
28 getting down in the \$4 cap payment. And that's a

1 real important issue. You see it all the time in the  
2 difference between those contracts.

3 CHAIRMAN ENTHOVEN: Right. Okay.  
4 Thank you very much. I think that this has been a  
5 great discussion.

6 We'll take about a five-minute break  
7 for the court reporter.

8 (Recess.)

9 CHAIRMAN ENTHOVEN: Will the Task Force  
10 members please -- will the meeting please come back  
11 to order. Let's see, a couple of announcements  
12 first. The written comments and the  
13 promised documentary material such as the data on the  
14 evolution of medical groups, on IPAs and so forth, we  
15 really need that real quickly, like Monday. We'd  
16 appreciate it if you would fax it to us on Monday or  
17 else get it in the mail on Monday or you can give  
18 them to me today. Put your name on it because our  
19 crew is going to be working through the weekend and  
20 on to be turning these things around, so we really  
21 need fast turnaround from everybody.

22 It turns out the state does not have  
23 the authority to buy us lunch and so we set up this  
24 process. But in order for us to be able to do this  
25 and order the meals, I had to either -- Phil or I had  
26 to, and I said, well, it's probably my prerogative to  
27 do this, is personally had to underwrite any  
28 financial loss except that we have your names. So we

1 do have names and whether I'm willing to do this  
2 again is going to depend on the size of my loss. But  
3 if we do it again, we're only going to include the  
4 people who paid this time. We'll publish a list of  
5 people who haven't paid.

6 MS. BOWNE: See, Alain, for risk  
7 adjustment you have to increase the price so that you  
8 have the money to put back.

9 CHAIRMAN ENTHOVEN: You're suggesting  
10 that I should consider this group as adverse  
11 selection?

12 Yes. Alice has a quick statement to  
13 make and then Phil.

14 MS. SINGH: Just FYI, you might want to  
15 know that the Yellow Cab Company only accepts time  
16 specific pickups and you need to give them one hour  
17 advanced notice. So I'm sorry, but that's what we've  
18 been told.

19 CHAIRMAN ENTHOVEN: Thank you.  
20 Phil.

21 DR. ROMERO: This is addressed to all  
22 of you if you're paying customers or free riders.  
23 All I want to do is take a moment and encourage the  
24 Task Force, all of you to give yourself a round of  
25 applause for getting through a very important  
26 substantive recommendation.

27 (Applause.)

28 CHAIRMAN ENTHOVEN: We're still --

1 message to the free riders, we're still about \$75  
2 short. As I say, we have the names if you want to be  
3 recognized at the next meeting.

4 We have a problem in which order to do  
5 things.

6 DR. NORTHWAY: Get the money first.

7 CHAIRMAN ENTHOVEN: I think that we  
8 need now to move to the expert resource group reports  
9 and discussions because these good people had to come  
10 prepared to present and so I propose that we do --  
11 unless this causes some big problem, you know,  
12 somebody has to leave or something, I suggest we do  
13 it in the order we've got them here simply because  
14 that's where we are.

15 And so we go to the doctor-patient  
16 relationship and after that -- spend an hour on that  
17 and then an hour on academic medical centers and  
18 health care work force. That should bring us to  
19 4:15. Then we could do one of the other papers. I'm  
20 inclined to think we would do the standardization  
21 benefits paper.

22 I might -- if we have a few minutes  
23 left over, I might just comment a little on balancing  
24 private and public sector roles.

25 So, Brad, Mark.

26 MR. GILBERT: What we'd like to do is  
27 do a fairly quick presentation to allow time for  
28 discussion. What I'm going to go through briefly is

1    what we did in terms of some of our work to prepare  
2    this paper.  First I want to --

3                   MR. LEE:  Do you have a paper in front  
4    of us?

5                   MR. GILBERT:  Yes.  You have an outline  
6    that was in your pile to the left.  It says,  
7    "Physician-Patient Relationship."

8                   MR. LEE:  Do we have extra copies  
9    somewhere because I don't --

10                  MR. GILBERT:  It's in the folder.  Does  
11   everybody got them?

12                  CHAIRMAN ENTHOVEN:  I don't.

13                  MR. GILBERT:  First, in keeping with  
14   other groups I want to thank Sara and Vicky for  
15   managing a lawyer who works collaboratively with  
16   HMOs, and HMO medical director, a person who  
17   represents the unions and the consumer and managing  
18   to get us to come to some level of consensus in our  
19   recommendations.

20                  What we've done is really four  
21   different things.  Number one is there were some  
22   comments that we had put in a letter from Bruce  
23   Livingston today about the whole issue of  
24   incorporating public hearing information into our  
25   process.  And I took very detailed notes at every  
26   hearing and specifically called out when individuals  
27   spoke about physician-patient relationship.  And so  
28   I've tried to do my best to incorporate that.

1                   Two, there was a semi-extensive review  
2 of the literature which included an article and many  
3 other articles, some of which the Task Force has  
4 seen.

5                   Three, we did something a little bit  
6 different. We had our own hearing because of this  
7 issue. We met actually because of the Brown Act  
8 Rule, and there were three of us rather than two. We  
9 were forced to -- we were told we had to notify about  
10 a meeting of the three of us. What that actually  
11 resulted in was a mini public hearing, and there were  
12 a number of individuals who came to the hearing and  
13 presented to us about the physician-patient  
14 relationships and actually gave us our own bit of  
15 public input, distinct and specific to our ERG which  
16 I thought was helpful.

17                  Finally, I think just in terms of  
18 myself, I have a lot of contact with our primary care  
19 physician, and so I spent quite a lot of time talking  
20 with them over this time period.

21                  What we try to do in this is -- in this  
22 outline in front of you was to identify the potential  
23 areas of concern or the areas of impact on the  
24 physician-patient relationship related to managed  
25 care.

26                  And so we then, within those big areas  
27 which the bold titles after the heads of the  
28 different sections, we tried to come up with sub

1 areas within those that we felt more further  
2 delineated details in those broad areas.

3                   We then -- what we're presenting to you  
4 today are initial priority recommendations. We had a  
5 whole series of recommendations under each one of  
6 these areas, some of which go quite closely with  
7 other groups, some of which are, I think, unique to  
8 us. And the ones that you're seeing today are  
9 priority recommendations, kind of along the lines  
10 that Peter is talking about, focusing on maybe the  
11 ones that potentially are more controversial or  
12 potentially difficult.

13                   What we're particularly interested in  
14 today, besides general discussion, is have we missed  
15 an area of concern, have we missed an area about the  
16 physician-patient relationship totally, have we  
17 missed a sub-area among the larger areas. So we  
18 would ask the group to focus on that.

19                   We're going to quickly present a little  
20 bit around each of the areas, give a few editorial  
21 comments on the recommendations. Mark and I have  
22 split them up, and then we'll open it up for  
23 discussion.

24                   So I'm going to start with continuity  
25 with a physician. Now, I think we have had quite a  
26 lot of discussion on this point, so I think I can  
27 shorten this even more than I would have done. But  
28 basically I think people know the issues in terms of

1 closed HMO panels, medical groups and specific sets  
2 of physicians that they contract with, and of course,  
3 HMOs of specific IPAs or medical groups or that kind  
4 of model that they contract with.

5 So the issue under this first one is  
6 just that when any individual signs up for an HMO,  
7 they're de facto to some extent limited to a  
8 particular PCP or/and specialist that they can see.

9 The second bullet under there is  
10 something that has come up before which is the whole  
11 issue about termination of a physician or an IPA's  
12 contract and how that termination of either an  
13 individual physician by an IPA or HMO, if there's  
14 direct contracting, or the termination of an IPA can  
15 result in disruption of the continuity of a  
16 physician-patient relationship.

17 A physician is terminated, they're your  
18 physician, you can't change your health plan because  
19 you're locked in for some period of time, you would  
20 have to pick a different physician if that one's no  
21 longer available.

22 Change in coverage by an employer  
23 obviously follows that. If your employer changes  
24 coverage you might have a whole different IPAs with  
25 whole different lists of physicians that you would be  
26 able to contract with.

27 Lack of choice and information under  
28 this bullet, what we were focusing on was the issue

1 that although potentially the information may be in  
2 the EOC that, Alain has correctly pointed out, I  
3 recently got mine at that EOC and never got through  
4 it, never even got close to getting through it, are  
5 individuals clearly aware of the specialty-care  
6 arrangements, is it a closed panel, is it a medical  
7 group where it's a totally closed panel, is it an IPA  
8 with a broad range of community specialists but still  
9 usually a specific set of specialists?

10                   So are consumers truly aware that even  
11 when they pick a medical group or particularly if  
12 they directly pick a PCP of what the arrangements are  
13 for specialty care? And that arrangement can be very  
14 limited or very broad and it can depend on whether  
15 it's an IPA, a group model, et cetera.

16                   So we were concerned that that lack of  
17 choice results in a situation where someone goes,  
18 "Wait a minute, I was followed by this specialist and  
19 now I no longer can have that relationship because it  
20 doesn't work within the group."

21                   From our perspective in Medi-Cal this  
22 happens all the of the time. Members who have been  
23 followed by specialists suddenly get into an  
24 arrangement where that becomes more difficult.

25                   So to look at the priority  
26 recommendations under this area, the two -- I want to  
27 start with the first two, and then actually I'm going  
28 to talk a little bit about one that's not on the

1 list.

2                   The first one is we used to require a  
3 lot. I think that there will probably be a lot of  
4 debate about this, and this is about four to six  
5 weeks old. So given a lot of our discussion this  
6 morning, that may bring up some issues. But first is  
7 to require health plans and medical group IPAs to  
8 write contractual arrangements that enable patients  
9 or potentially a subset of patients to continue  
10 seeing their doctors until the end of a contract  
11 year.

12                   Now, there are clearly some very  
13 difficult logistics to this, and I think the group  
14 has talked about the fact that the time frames  
15 between the reenrollment of an IPA, the recontracting  
16 of an IPA with an HMO that is severed and the open  
17 enrollment period that those can be discontinuous  
18 resulting in the individuals losing their  
19 physician-patient relationship without being able to  
20 do anything about it in terms of open enrollment  
21 through their employer. So the logistics are quite  
22 difficult. Many plans, and our plan has a policy  
23 where patients who roll into us from the Medi-Cal  
24 process, if they're in an episode of care, are  
25 allowed to continue with that specialist regardless  
26 of the affiliation. And we simply make the --  
27 simply, we make the IPA or hospital responsible pay  
28 that specialist on a fee-for-service basis for those

1 services.

2 But that is only in the circumstance  
3 where someone is rolling into the plan. It would not  
4 take care of an employer situation where the coverage  
5 or PCP, IPA, was lost midstream.

6 So there was a lot of discussion about  
7 this in the group. My feeling was that I was a  
8 little bit biased towards more of a subset of members  
9 that are clearly in episodes of care in care plans  
10 versus everybody because you might be trying to  
11 create continuity with a patient that's never seen  
12 that doctor in a year or two, which is true for many  
13 people that are healthy that don't go in, you know,  
14 more frequently than once a year.

15 So I think there would need to be some  
16 discussion about certainly the logistics, the  
17 mechanics, and who we would talk about.

18 The second recommendation in this area  
19 is to require disclosure of PCPs, medical groups or  
20 IPAs during enrollment as well as specialists  
21 affiliated with the group and explain the access  
22 limitation.

23 We had a discussion about a super  
24 directory. Mark and I have had further discussion  
25 about that and are concerned about the ability to  
26 really do that. It's doable, of course, I mean our  
27 health planning can produce it, but some of the  
28 bigger health plans you would be talking about a very

1 large book, and I'm not sure always how useful that  
2 would be.

3                   Two is the issue of trying to have  
4 people understand when they pick -- when they pick a  
5 particular group or they pick a PCP, what are the  
6 implications of that in terms of their ability to  
7 access the specialists. I have a specialist they  
8 have previously seen or in general the whole  
9 in-network or out-of-network providers. So somehow  
10 having a disclosure to individuals either through the  
11 EOC or other mechanism where they understand exactly  
12 what -- well, not exactly, but what the access  
13 limitations potentially could be when they make that  
14 choice.

15                   The third one that's not on your page  
16 was on our original set of recommendations and is a  
17 bit of a controversial one, even within the group,  
18 and I think certainly will be subject for discussion  
19 here. But we -- and so this one's not on the paper  
20 in front of you -- was to require explanations -- the  
21 way we wrote it was require explanations or reasons  
22 when physicians are terminated or other providers are  
23 terminated.

24                   And we -- the point here that we're  
25 trying to figure out how to deal with the no-cause  
26 termination issue and speaking for myself, the -- my  
27 personal contracts with my health plan has a no-cause  
28 clause and they can fire me for any reason. But I

1 don't directly care for individuals. I mean, I  
2 believe, you know, hopefully that my role is  
3 important, but I don't care for patients directly.

4                   So I think this issue we've got to  
5 grapple with that problem between the need for  
6 contractual relationship and flexibility in those  
7 contractual relationships versus the fact that there  
8 are physician-patient relationships that could be  
9 negatively impacted if a physician is terminated for  
10 no specific reason.

11                   Now, we would -- we as part of that  
12 expressly said that business reasons or network  
13 reasons could be a reason that doesn't necessarily  
14 have to be quality or other -- other indicators that  
15 could exist, that it could just be business or  
16 network but that there had to be something beyond  
17 simply no longer having that physician. We certainly  
18 heard testimony from one physician that's been -- I  
19 think it was Ventura County who -- a pediatrician  
20 who, you know, certainly the timing was interesting  
21 in that regard.

22                   So those are the initial -- the third  
23 bullet on your priority recommendations I see is  
24 really identical to the second bullet, so you've now  
25 got three bullets under that, the first two and then  
26 the one I just raised.

27                   What we would like to do is we're going  
28 to be imparting a fair amount of information, we

1 would like to just keep going and then have a  
2 discussion on all areas at the end.

3 Second one, quality improvement  
4 programs.

5 Two issues here we felt were a problem.  
6 Increased paperwork and someone said it very nicely  
7 early in one of our meetings about promise of less  
8 paperwork under managed care and you don't have to do  
9 billing, you don't have to do certain things  
10 theoretically under capitation model.

11 The fact is that most of my physicians  
12 believe that the paperwork has substantially  
13 increased under managed care because of required  
14 forms and assessments and quality indicator things  
15 and so on. And so we saw that as a potential issue  
16 because that takes time away from the patient for the  
17 physician.

18 Two, and I think Jeanne really  
19 addressed this in her group regarding consumer  
20 information so I won't spend too much time on it, is  
21 the whole issue of the patient having knowledge of  
22 quality indicators or information that allows them to  
23 make meaningful choices about their choice of  
24 physician or medical group. And I think we've kind  
25 of beat that one into the ground, so I won't talk  
26 about that one too much.

27 The recommendations of streamlining  
28 physician audits was something that was specifically

1 addressed in legislation, although the legislation I  
2 saw didn't talk about the methodology. Our  
3 physicians are driven crazy by the multiple physician  
4 office audits.

5                   The argument I use which is kind of  
6 pathetic and doesn't work very well is I say if you  
7 can pass ours -- because we have a DHS mandated audit  
8 that is, in fact, I believe the most rigorous  
9 compared to all the other office audits that I've  
10 seen, and I've looked at quite a few from a lot of  
11 HMOs. So I use this sad argument that if you pass  
12 mine, you can pass anybody's. And so that doesn't  
13 fly very well with our PCP.

14                   So I am in support of, and our group is  
15 in very support of, trying to come up with a standard  
16 office audit that can be agreed to as a standard for  
17 the industry and when a doctor passes that audit and  
18 you have the standard for the audit, you have the  
19 standard for how the audit is scored, so that I can  
20 believe and trust in someone else's audit in terms of  
21 the quality of it, then I think we can probably get  
22 to a point where HMOs would generally accept that.  
23 There's been a little bit of work in that in some  
24 areas, but the audits I've seen that are standardized  
25 haven't really been to me rigorous or of high enough  
26 quality. But I think that's doable.

27                   And then the second recommendation  
28 under this area is what we talked about and I think

1     that that really probably will be handled quite a bit  
2     in the consumer information.

3                     Next, Mark, 3 and 4.

4                     MR. HIEPLER: I think that if we look  
5     at why we were caused to exist here and you look at  
6     the focal point of the whole medical system, it  
7     begins with the doctor and the patient. And so I  
8     think that -- just a general comment -- we have to  
9     look at all decisions that we make even on the  
10    technical areas of risk assessment and areas that  
11    seem wholly unrelated almost to the doctor-patient  
12    relationship. We need to look at those decisions and  
13    recommendations and have the threshold question of  
14    how does this affect the doctor-patient relationship.  
15    Because kind of like the agrarian myth, do we still  
16    believe in the doctor-patient relationship or is it  
17    simply becoming a myth with the coporatization and  
18    the controls that are placed on that relationship?  
19    And the CMA gave us a wonderful document that kind of  
20    summarizes the doctor-patient relationship, it's on  
21    page 3 of the September 22nd document. It  
22    says:

23                     "The foundation of the  
24                     physician-patient relationship is  
25                     a trust that physicians are  
26                     dedicated first and foremost to  
27                     serving the needs of the  
28                     patients. It is this trust that

1 enables patients to communicate  
2 private information and to place  
3 their health in the hands of  
4 physicians. Without trust the  
5 success of the healing process is  
6 seriously diminished.  
7 Unfortunately, this trust is  
8 being threatened by increasing  
9 fears among patients that health  
10 plans rather than health care  
11 professionals control critical  
12 decisions about their medical  
13 care."

14 And again, whether that is perception,  
15 reality or a mix of both, it is a concern. And so  
16 part of the what we bring is from the hearing that we  
17 had and also I've been involved in probably about 140  
18 issues where people have been denied care and there's  
19 a question as to whether it was legitimate or not.  
20 Also, I happened to have represented a whole stream  
21 of doctors who because of advocacy, they believe,  
22 were suddenly given a termination, and we've seen  
23 where doctors based on calls from different people  
24 have completely changed their patient recommendation,  
25 and in many cases where patients weren't even told of  
26 different options because of the payment mechanism.  
27 And again, some of those are isolated and some of  
28 those are rampant.

1                   And so what we've looked at in the  
2 gatekeeper role of the primary-care physician  
3 utilization review were four big points. And our  
4 office alone gets 150 calls a month from people all  
5 over California who are just lost in the HMO service.  
6 We give about 50 hours of free coaching on the phone  
7 how to get a referral.

8                   And if you remember Dr. Spurlock and  
9 Dr. Alpert's big issue and Dr. Alpert's continuing  
10 question of why is there so much concern, why do we  
11 have an HMO Task Force? One component area as I go  
12 through now several thousand have just requests for  
13 help that our office has given, it does focus a lot  
14 at the medical group and it focuses a lot about  
15 trying to get what the patient believes they need to  
16 what they at least believe their primary-care  
17 physician believes they need.

18                  And so in looking at these based on our  
19 hearing and some of these things will not have peer  
20 review journal articles on. I know there is some,  
21 but not everything in the patient-physician  
22 relationship is quantifiable, partly because how do  
23 you quantify trust.

24                  But four categories that were  
25 identified and then there was full agreement on, and  
26 Brad has been very cooperative in this as well as  
27 John who is not here, is controlling access to  
28 specialists, specialist to specialist referrals to

1 the people who are in greatest need, and whether it's  
2 really cost effective to force them to go back to the  
3 primary-care physician, denying unnecessary  
4 procedures and tests and then in network versus out  
5 of network providers, whether there are suitable  
6 people and you heard Harry Christie's testimony about  
7 his situation with Carly, whether there are adequate  
8 people within the network and if it's a closed  
9 network, do they have people who can really give  
10 medically necessary care.

11                   Priority recommendations are -- we have  
12 a couple of them, and if I can start first. One of  
13 the things that I would like to continue to encourage  
14 everybody to do -- and our group has maybe done a  
15 little of this -- is to try to be bold in our  
16 initiatives, don't be afraid that, man, someone may  
17 not like them, and we're going to fight over the real  
18 things. But at the end of this if we've given no  
19 real concern or if we haven't been bold in anything,  
20 people will think that this was a whole waste of  
21 time. So one of the most bold initiatives, and we've  
22 got Brad's agreement on it, and Brad was right with  
23 it, was the fact that that first point was that  
24 physicians who are terminated, they should be given  
25 some reason besides just the times up, because most  
26 of the clauses have a 45-day clause saying we don't  
27 have to give you any reason, within 45 days you're  
28 gone, and especially to the physicians who have a

1 very large percentage of one HMO that dominates a  
2 geographical area, there's a real concern if they  
3 buck the system, if they advocate for a patient, if  
4 they do something that fosters the trust of the  
5 doctor-patient relationship, if that's why they're  
6 being tossed out or if there's other reasons.

7                   And as Brad indicated, if I can quote  
8 you, you know, they should stand up, the health plan,  
9 the medical group should stand up and explain some of  
10 that. Why not? If there's a real legitimate reason  
11 other than an advocacy, explain it to them. Let the  
12 doctor know. Physicians come in all the time who  
13 say, you know, we just lost 50 percent of our  
14 practice, I'm moving to Louisiana, we don't know why  
15 we were terminated, and then they find out Louisiana  
16 is not as good as they thought and they go to Texas.  
17 So you're never sure what's happening there.

18                   Brad and I have a disagreement on this,  
19 it didn't make it into your sheet under priority  
20 recommendations, is to basically side with Dr. Alpert  
21 and Dr. Spurlock and, number one, do away with prior  
22 authorization requirements for specialty visits.  
23 Several HMOs in response to the market system have  
24 already started to do that one way or another. But  
25 what happens when you do that is, first of all, you  
26 force the HMO or the IPA to do a better job in  
27 selecting their primary care physicians, physicians  
28 that they have to trust a little bit so that the

1 patient isn't kept from that referral, isn't kept  
2 from given an unnecessary waiting period, and that's  
3 one of the places where you get the most complaints,  
4 it forces them to sign up people that they can trust  
5 their decisions about whether they indoctrinate them  
6 to begin with or not, that may be a problem down the  
7 line, but that is one area where we just see  
8 continued frustration and continued negative results,  
9 whether it's just an asthma treatment that doesn't  
10 happen or a dermatological treatment or if it is, in  
11 fact, something where cancer goes undiagnosed, and we  
12 represent many people in those areas. So it forces  
13 them to just be more accountable, to hire the proper  
14 people.

15                   Secondly, it would reduce the  
16 frustration that patients and doctors have and that  
17 hassle factor, especially in that capitated  
18 environment. They do not get paid to be on the  
19 phone. And the office staff, they have to hire extra  
20 office staff just to try to get referrals. And the  
21 worse thing that often happens is there isn't an  
22 advocacy and they're not going to pay for it and the  
23 patient is left and then they end up calling lawyers.

24                   Three, reduce malpractice claims and  
25 claim for failure to diagnose. If the referral  
26 process can go through, it can significantly reduce  
27 both of those and there's not a basis for the lack of  
28 referral or there's not a financial impediment for

1 the primary-care physician to refer.

2                   Fourth, it allows doctors to practice  
3 in their specialty. What we're finding more and more  
4 in abundant amount of lawsuits, and we've done  
5 statistical research of this, is that you have  
6 gatekeeper physicians having to practice in about six  
7 specialties because they can't afford to make the  
8 referral because of the financial incentives against  
9 referral, and often -- some of them maybe can do it,  
10 but that's a pretty good thing, and when there is a  
11 mistake, the patient is the first harmed and then the  
12 doctor finds themselves in litigation. That would  
13 increase the time that could be spent with the  
14 patient and not on the phone trying to approve  
15 referrals.

16                   I think a more modest approach, and  
17 this is one that Brad even agrees on, and that is  
18 the second one and the one that's listed, is to set a  
19 time period, two years or so, by which a PCP can earn  
20 a gold card, that's basically earning the trust of  
21 the IPA or if it's a direct contract with the HMO,  
22 allowing them to be exempt from prior authorization  
23 and to encourage prescreening of physicians for  
24 quality. And you can see that that's a more modest  
25 step in the direction than Dr. Spurlock, Alpert and I  
26 have kind of advocated. And again that's fairly  
27 bold, but that is one of the heart in the center of  
28 complaints is getting into the hands of the proper

1 specialist and whether or not that is happening.

2 MR. HARTSHORN: Mark, could you back up  
3 to malpractice insurance because I was looking for it  
4 and I didn't see it and didn't hear you.

5 MR. HIEPLER: It's not on the sheet,  
6 I'm just giving you rationales as to why I think it  
7 would help --

8 MR. HARTSHORN: Just back up.

9 MR. HIEPLER: -- increasingly. And one  
10 of the main target areas in malpractice claims is the  
11 primary-care physician, again, bearing all the risk  
12 because the referral didn't go through. And  
13 typically this is in a failure to diagnose a cancer,  
14 and it's the most extreme, tragic extremes for  
15 patients and then it's an extreme situation for  
16 doctors too. And this would eliminate that  
17 hinderance or that potential claim that it's based on  
18 inability to refer, that would take the liability  
19 hooks off the medical group as well as the physician  
20 where there is that tendency not to refer because of  
21 the bureaucracy or the delay in the processing of  
22 that referral.

23 Again to reduce litigation I think it  
24 would be a great step in the direction, plus it would  
25 help foster, I think, the trust relationship that is  
26 at question between the doctor-patient relationship  
27 because are you not referring me because there is  
28 incentive not to. Did that --

1 MR. HARTSHORN: Yes. Thanks.

2 MR. HIEPLER: -- encourage HMOs to let  
3 specialist PCPs for chronically ill members? Did  
4 that make it onto yours? We found that especially in  
5 the treatment of oncology patients. It's completely  
6 ridiculous to force them to go to the PCP every week  
7 before they go get the chemotherapy treatments. Many  
8 groups still process their specialty referrals that  
9 way. Everything you get. So if you have a  
10 chronically ill patient, they can approve the  
11 treatment plan over six months. It's more efficient  
12 for the bureaucracy of the health plan, it's best for  
13 the patient and for the physicians involved.

14 And again, encourage "shoulds" or  
15 "shalls" are things we can debate, but these are  
16 broad topics for our discussion.

17 Require explanations for referral  
18 denials, require disclosure of the basis for medical  
19 necessity decisions. Often the patient doesn't know  
20 where this is coming from, it hasn't been processed,  
21 they don't know if it's the UR at their local medical  
22 group, and if so, they should talk to them. They  
23 don't know if it's the HMO on high or the corporate  
24 HMO that is denying it or they don't know if its  
25 their primary-care physician who doesn't want to  
26 refer for good reason or bad reason or indifferent  
27 reasons.

28 So require a denial to state who is

1 actually denying this thing, because that's where  
2 people get lost and there's a lot of HMO time that is  
3 spent, I believe, inefficiently in trying to see who  
4 denied it and they didn't deny it, it was the medical  
5 group. And the medical group wondering who did it at  
6 UR and it was just the referral didn't get passed  
7 through by the primary-care physician. It allows  
8 accountability and takes away the frustration factor  
9 that doctors and patients are feeling getting lost in  
10 that process.

11                   The fourth category in financial  
12 incentives and I'll go through this fairly quickly  
13 because we've had a lot of discussion on this. But  
14 the real concern is that in especially IPA models  
15 we're seeing capitated arrangements, and again, I  
16 can't get these contracts except for spending  
17 probably \$20,000 of time a year or so of litigation  
18 and getting a court order to actually be able to tell  
19 the patient how much their physician is being paid,  
20 and most of the time it is such a small amount that  
21 it would be very alarming.

22                   In the IPA model we're seeing contract  
23 \$7 and less per member per month, and again, not risk  
24 adjusted, but the patient thinks and believes that  
25 most of these are fee-for-service situations. So  
26 they're not empowered to ask the proper questions to  
27 find out where the possible incentive is to treat or  
28 not to treat or if that's even a reason why they're

1 not getting processed. And if we can disclose that,  
2 we can take away a lot of the concern plus we can  
3 allow people up front to know what they're getting  
4 and to have expectations accordingly.

5                   And basically the big shift that we're  
6 seeing is the patient is still operating under the  
7 idea that they're in a fee-for-service with  
8 retrospective review, but when they don't get to the  
9 next step they're finally realizing that there's  
10 prospective review. In retrospective review there's  
11 a business decision, there's a business damage,  
12 there's dollars for the payment of the care already  
13 received.

14                   And the prospective review you have two  
15 categories of damages, you have the human costs, you  
16 have the frustrations of the doctor and then the  
17 second category is also the financial issue. So if  
18 they know up front, and we all have talked and we've  
19 heard everybody say patients need more information,  
20 if we don't give them the fundamental information on  
21 how the physician's paid and how the system works,  
22 we're losing it. And to the degree that I have to go  
23 through that much strain to get a copy of these  
24 contracts, you know, it's a symptom that is something  
25 that people don't want the patient to know to allow  
26 them to police their own doctor, their own medical  
27 group in their own possible way. And it fosters  
28 trust if they know how the system works to know how

1 the doctors pay.

2                   So the risk pool situation as you've  
3 heard a couple of people have asked to have these  
4 described. Often there is an actuarial based and  
5 most often non actuarial-based risk pool to  
6 supplement the capitated amount.

7                   The risk pool generally in most of the  
8 contracts says that if you do not use this money for  
9 referrals to specialists, and there's also hospital  
10 pools, if you don't use the hospital to a certain  
11 degree, the medical group and/or doctor will get 50  
12 cents of every dollar back that they don't use at the  
13 end of the year.

14                   In a meeting with a large medical group  
15 recently they said they cannot survive on the  
16 capitation, yet the HMO indicated that the risk pool  
17 was actuarially based, this was how much they were  
18 going to need.

19                   So that leaves them with no decision  
20 other than to take money out of the risk pool or make  
21 sure there is risk pool money to help them supply the  
22 way they are going to give services. There's a real  
23 conflict there, and again, doesn't need a lot of  
24 regulation, just needs some light, and that needs to  
25 be allowed to be disclosed to the patient because  
26 many of the contracts say you cannot -- it's not a  
27 per se GAG clause, it's an indirect GAG clause. You  
28 as the physician are not to disclose the proprietary

1 information the way that you're paid or the method  
2 and means of the dollar figure.

3 Well, the physicians are concerned  
4 about disclosing that even though it's not a GAG  
5 clause, but it keeps the patient from ever knowing.  
6 At many medical conventions there are doctors that  
7 say, "I want my patients to know I am getting \$7 per  
8 month, they'll think I'm giving pretty good care for  
9 that." And so the requirement is to require  
10 disclosure of physician compensation to patients and  
11 other physicians, provider incentives, recommendation  
12 from the ERG we've discussed.

13 In addition, capitation of other  
14 medical providers seemingly one of the goals is to,  
15 again, remove the risks from the HMO, place the risk  
16 on all of the care providers.

17 There's good philosophical reasons,  
18 practical reasons. I don't know if it works or not,  
19 but I think a patient should know if the person  
20 reading their Pap smear is getting .01 per month  
21 capitated because when my slide or biopsy goes in  
22 there I want to know whether it's a volume place,  
23 whether it's a careful place or whether they're  
24 getting paid. So one of the bolder requirements is  
25 that if something's being capitated it should be set  
26 forth where a patient can find out and actually look  
27 it up. It also helps them to compare ahead of time  
28 when they're shopping as to what is capitated, what

1 is not and who's getting more of the money. Is my  
2 physician ever getting anything out of this processor  
3 or is it all lost on administration. Also, it's a  
4 good angle for the HMOs to show the large percentage  
5 that may be going to the hospital and to the  
6 physician.

7 We were supposed to divide up the  
8 section for Mr. Perez in informing patients of all  
9 options.

10 Again, we have seen a lot of contracts  
11 and recommendations from executives at different  
12 levels at the plan or at the medical group level that  
13 says, you know, we're not paying for any of these  
14 options so the physician should not even discuss the  
15 option because then it will result in litigation and  
16 there's all kinds of conflicts.

17 Those are subtle GAG rules. And  
18 basically our position should be that the physician  
19 should be empowered, as you would expect, to discuss  
20 all options, whether it's a covered benefit or not,  
21 and that's an insurance determination and of course  
22 you can't pay for anything, but at least the patient  
23 should be able to have disclosure of all things, and  
24 disease management guidelines, how the doctor is  
25 perhaps being told how to manage a disease, that will  
26 help give credibility that there is a plan, that it  
27 is not just based on how they're paid. We think  
28 that's very positive. So the big regulatory portion

1 of this is basically disclosure.

2 Priority recommendations. Requiring  
3 the following information on the patient's health  
4 insurance card, this wasn't a big issue. Some of the  
5 staff people helped us come up with this. I think it  
6 may be important, type of health plan, whether the  
7 PCP referral is required.

8 Several physician front office people  
9 came up and told us that people don't even know what  
10 they're in. And the cards don't give these simple  
11 things, and the patient says I don't need a referral,  
12 and the plan says they need a referral, and the front  
13 office of the doctor's office are completely  
14 frustrated, whether copayments are included or  
15 excluded, what services are excluded and whether  
16 referrals are confined to the PCPs medical group,  
17 required disclosure of the physician's compensation  
18 to patient.

19 And this should come from the HMO  
20 level, the physician doesn't necessarily have time to  
21 sit, you know, and go through all of that when their  
22 time is already maxed with just the volume  
23 constraints that they have in many capitated  
24 situations.

25 So the concern there is that a list of  
26 information be provided at the medical group level  
27 that anybody that receives a capitation payment in  
28 the plan, it should be set forth and told what that

1 actually is.

2                   There's been some legislation in part  
3 as a result of the Ching case in Rosenthal's office  
4 to say that you need to talk about risk pools, but  
5 again, a lot of people here don't even understand the  
6 term much less a person who is getting their little  
7 booklet.

8                   But people want to understand, "What is  
9 my doctor getting paid?" It's a very important part.  
10 It's not going to solve all problems, it allows some  
11 sunshine to be on some issues, and I think will help  
12 foster that trust issue.

13                   The physician availability goes back to  
14 Brad, right?

15                   MR. GILBERT: I'm looking forward to  
16 hearing the consequence of your Pap smear, by the  
17 way.                   Mark says we're in agreement,  
18 it's not because he said he wouldn't sue Inland  
19 Empire Health. I actually thought I was with a  
20 different health plan that would encourage him.

21                   Physician availability I wanted to talk  
22 about fairly quickly. Inadequate visit time, really  
23 two issues even under any model, staff models have  
24 productivity guidelines and requirements. IPA models  
25 you have to have lots of patients. If you're getting  
26 \$7 per member per month your total is on the low end  
27 of most contracts, you need a whole lot of patients  
28 to make that work, which means many patients need

1 appointments and you may not have time to fit them  
2 all in. So we believe there may be some issues in  
3 terms of inadequate visit time.

4 I would just point out and I think some  
5 of the physicians could here as well that I've worked  
6 under virtually under any system if you're in a busy  
7 clinic, you're in a busy clinic. It doesn't matter  
8 how you're getting paid. I've worked in every  
9 setting from capitated fee-for-service, withholds,  
10 everything, and I'm not sure I can really tell the  
11 difference, but certainly there's perception or  
12 concern that lots of patients for an IPA model or  
13 productivity requirements of a staff model may cause  
14 problems.

15 Appointment availability. This is a  
16 tough one. There's a lot of studies that are done,  
17 and in some ways I think that managed care  
18 potentially improved in some areas because they  
19 measure it, it was never really measured in any  
20 systematic way before, hopefully that measurement  
21 results in change. But what is reasonable. It all  
22 probably depends on what type of thing you need,  
23 whether it's an acute visit or preventive or health  
24 assessment visit. But that's certainly an area where  
25 people are concerned because they're told you can't  
26 get in for six weeks, eight weeks, ten weeks, et  
27 cetera.

28 Physician standards. This one was

1 actually something that came up which was talking  
2 about the issue of the increasing use of physician  
3 assistants and nurse practitioners because of related  
4 theoretically to compensation and the fact that those  
5 individuals do not cost as much as physicians and  
6 therefore get used more.

7 I think you know in many cases that's  
8 completely appropriate. In many cases nurse  
9 practitioners and PAs -- I hesitate to say this --  
10 can do a better job than a physician in terms of some  
11 of the education on preventive issues. But to me,  
12 the issue is the management and supervision of those  
13 individuals and we focus a little bit about that in  
14 our recommendations.

15 Development of the doctor-patient  
16 relationship is obviously, as Mark said, the core of  
17 the whole thing. And there's a sense or a ground  
18 swell which Dr. Alpert always talks about,  
19 something's happening and that's getting eroded. And  
20 clearly, that could relate to the inadequate visit  
21 time, the appointment availability, use of physician  
22 extenders, all of those things could erode a clear  
23 type close physician-patient relationship which I  
24 think all of us would agree is obviously key to good  
25 medical care at some level. So those would be  
26 impacted by the things above.

27 As far as the other recommendations, I  
28 think we beat risk adjustment into death this morning

1     so I won't talk anything about that.

2                     This second one, there is some conflict  
3     in this area in terms of this issue, there are  
4     different laws around the supervision and oversight  
5     of physician extenders. It's different for nurse  
6     practitioners than physician assistants. It's very  
7     different actually in the law and so there was some  
8     discussion about whether physicians need to be  
9     present for that supervision and whether or not the  
10    disclosure needs to be done as to whether an  
11    appointment is with a physician, a physician  
12    extender, you know, hopefully that occurs. But there  
13    was a little bit of discussion about that.

14                    The final priority recommendation which  
15    is not on your sheet was discussions about maybe  
16    the -- either the performance of access studies which  
17    virtually every HMO does, but in some ways maybe the  
18    publicizing and the information related to those  
19    access studies because I'm convinced in my area that  
20    access has been improved and I have appointment  
21    availability studies that I think demonstrate it.  
22    But I don't have a good baseline in terms of Medi-Cal  
23    fee-for-service in my particular circumstances to  
24    compare.

25                    So those are our areas with the sub  
26    areas our initial priority recommendations. There  
27    is, of course, an entire paper being created with  
28    cites, with footnotes, hopefully balanced after the

1 discussion this morning, at least in terms of the  
2 presentation, and many, many more recommendations.  
3 But we wanted to just throw out and get some  
4 discussion so that the staff helping us with the  
5 paper would have some ideas in terms of direction.  
6 So I open it up for questions or comments.

7 CHAIRMAN ENTHOVEN: Thank you.  
8 Mr. Gallegos.

9 HONORABLE GALLEGOS: Thank you,  
10 Mr. Chairman.

11 Brad, going back to number one and  
12 specifically looking at termination of physician  
13 contracts. Was there any discussion at all when you  
14 talked about, you know, termination of physicians and  
15 there should be a requirement to let them know the  
16 reasons for termination? Was there any discussion at  
17 all about a process that the doctors could use once  
18 they're notified of the reasons for their  
19 termination?

20 MR. GILBERT: There was discussion, and  
21 you could look at it one of two ways. In some sense,  
22 if you're doing it for cause, then there should be,  
23 of course, due process related to that for cause and  
24 your ability to, you know, show your side or your  
25 issues related to that.

26 So we had a discussion about explicitly  
27 linking those two because if you do for cause, then  
28 there should be some due process about that cause.

1 It didn't make it into the recommendation because we  
2 were a little bit -- you know, we waffled a little  
3 bit on the issue saying you can't have no cause  
4 versus giving explanations.

5                   So one of the problems would be if it's  
6 a business of network issue, is there really, you  
7 know -- is there really a due process related to a  
8 business or network decision versus, of course, a  
9 quality or a substandard care or those kind of  
10 things.

11                   HONORABLE GALLEGOS: What was the  
12 feeling about the business or network reasons? Maybe  
13 I missed this. Should there in your opinion or in  
14 your committee's opinion be a process for the  
15 physicians that are terminated for those reasons?

16                   MR. GILBERT: I think I can safely say  
17 yes. I think in terms of the committee I would say  
18 yes.

19                   HONORABLE GALLEGOS: So that would be  
20 your recommendation as something the overall Task  
21 Force should consider?

22                   MR. GILBERT: We had a lot of  
23 discussion about it, and I can say the three people  
24 sitting here agree on that, or the two and the empty  
25 chair.

26                   HONORABLE GALLEGOS: What about --  
27 excuse me, Mr. Chairman, if I could. What about  
28 notifying the enrollees of the doctor's pending

1 termination of contract so that they know ahead of  
2 time that, you know, on "X" and such date doctor's  
3 contract is going to be terminated or is scheduled to  
4 be terminated and they have, you know, advanced  
5 notice of that so that, you know, they don't come in  
6 the day after the doctor's been terminated because of  
7 a contract expiring the doctor's not there anymore.

8 MR. GILBERT: We didn't explicitly  
9 discuss that. I think, you know, in many cases  
10 health plans have specific obligations in certain  
11 areas, Medi-Cal for example, there is specific  
12 notification requirements when a physician is moving  
13 from the plan in terms of the time frame we have to  
14 give to the member to be able to make decisions, and  
15 that's true for Medi-Cal. I don't know if that same  
16 requirement is in the other, but we didn't  
17 specifically discuss that. But it's a good point.

18 HONORABLE GALLEGOS: And then lastly,  
19 the recurring theme through all your requirements is  
20 disclosure requirements on the part of the plans or  
21 the medical groups. It's pretty prevalent  
22 throughout. You know, given that there's been  
23 resistance, that's putting it mildly, that I've seen  
24 on the part of the industry with regards to  
25 legislation, that attempts to prompt disclosure in  
26 many of these areas that you've already addressed,  
27 what would be your recommendation for the Task Force  
28 on that issue? Would it be to, you know, pursue more

1 disclosure requirements or more patient information  
2 to, you know, the enrollees since that seems to be a  
3 strong theme throughout your paper?

4 MR. HIEPLER: Brad tossed me the mike  
5 on this one. I think it should say "shall." "Our  
6 recommendation that this information on capitated  
7 payments shall be disclosed or made available to each  
8 enrollee." And that's one area. And if you look at  
9 the CMA's large paper, they're very concerned about  
10 the impact that capitation has, whether it's -- and  
11 many of you, I think, when I spoke on that before  
12 said, "Oh, that's not a big deal, people. There's  
13 not even that great of an argument for it." So I  
14 think that's a recommendation.

15 MR. GILBERT: I think Mr. Gallegos is  
16 right, we have a pretty unique group here. I come  
17 completely from the public sector as I think you  
18 know. And I am in agreement with much of this  
19 because I don't see -- although there are certainly  
20 anticompetitive issues that may exist, many of the  
21 things I think are reasonable for patients to  
22 understand in terms of the delivery of health care so  
23 we were in consensus in terms of our recommendation.

24 HONORABLE GALLEGOS: What was it that  
25 you said would happen if the provider's contract  
26 expired before open enrollment? Did you recommend  
27 that the enrollee be able to continue care if there  
28 was on-going treatment? Did I hear you say that?

1                   MR. GILBERT: I think the consensus of  
2   our group was that it should be a subset of members  
3   that are in an episode -- there are a variety of ways  
4   to say it -- are in an episode of care, have a  
5   chronic medical condition requiring frequent follow  
6   up. There's many ways.

7                   The DOC has actually required health  
8   plans to file a continuity of care policy which is  
9   supposed to define the transition from one plan to  
10  another. So it covers that transition when you leave  
11  one health plan and you go to another. This is the  
12  circumstance where the individual's caught up in the  
13  middle of their period because of some change in the  
14  network. And our feeling was that, you know, if  
15  you're supposed to have a continuity of care policy  
16  or structure from one policy to another, why wouldn't  
17  that be applicable if the plan or group is making a  
18  decision in the middle of the period to do that? So  
19  really our focus was more on individuals that are  
20  clearly in some ongoing episode of care.

21                  CHAIRMAN ENTHOVEN: Excuse me, I just  
22  need to take care of a couple of things. We started  
23  this at 2:15, and now we're after 3:00. What I think  
24  I absolutely have to protect is the time to have the  
25  expert resource group on medical centers and health  
26  care work force for them to present, and then we can  
27  consider what we want to do about the other papers,  
28  perhaps roll them forward. So I think we're

1 absolutely going to have to end this one about 3:45,  
2 say another half hour.

3 The other thought is whether to try to  
4 organize the discussion around the Roman numerals as  
5 opposed to responding to the whole thing. Does that  
6 make sense?

7 MR. GILBERT: I think that would be  
8 fine.

9 CHAIRMAN ENTHOVEN: Okay. So could we  
10 ask for people who want to comment on Roman numeral  
11 I, may we just start a new list. Bud, are you  
12 wanting to comment on?

13 Barbara and then Bruce, Roman numeral  
14 I.

15 MR. LEE: I've got -- my comments were  
16 not on either of them, they were overall comments.

17 MS. DECKER: Then you have to go to the  
18 end.

19 MR. LEE: Fine. I'll go to the end.  
20 Fine.

21 CHAIRMAN ENTHOVEN: Tie it into the  
22 best place you can.

23 MR. LEE: Fine.

24 MS. DECKER: I agree with you from the  
25 reality base that it's very important for a patient  
26 to continue in care when they've established a  
27 treatment plan with a provider. So I conceptually  
28 find that attractive, and we do do this as we change

1 our plan offering. As an employer we look for the  
2 new plan to have some kind of transition from the  
3 prior plan.

4 But I'm just concerned about this idea  
5 of contract years. I just seen that as being very  
6 difficult and very torturous when people, different  
7 companies have different open enrollment periods,  
8 different years, claim years that they run on. My  
9 memory is that CalPERS is not on a 1-1 to 12-31. Oh,  
10 they are?

11 MR. GILBERT: No. You're correct. Our  
12 open enrollment was June.

13 MS. DECKER: Whatever. I think  
14 different employers can choose to have different plan  
15 years. And supposedly so every contract's supposed  
16 to run 1-1 to 12-31, and that seems fairly  
17 unsupportable from a business standpoint.

18 So how does this work when you say if a  
19 contract ends with a group, that the care must be  
20 continued with that group under a new arrangement?  
21 It just -- I don't see how that can really work in  
22 the world of today.

23 MR. GILBERT: I mean the logistics are  
24 difficult. One way to bring it to the base level  
25 avoiding the contract issue which I think is very  
26 difficult is that you do it at the physician level  
27 which is one way. If a person has an ongoing -- is  
28 in an ongoing episode of care with a specific

1 physician, that if the contract has changed, the new  
2 group that comes in as a responsibility for that  
3 episodes of care, to pay that physician regardless of  
4 whether they're with the group on some base fee for  
5 service basis. So then you would avoid your contract  
6 problems, but you would maintain the  
7 physician-patient relationship.

8 That has its own problems, obviously,  
9 in terms of ability to pay, quality issues,  
10 monitoring, oversight.

11 MS. BOWNE: For how long?

12 MR. GILBERT: And for how long. We  
13 actually -- the way we do it is episode of care we  
14 define episode of care which has potential downsides.

15 MS. BOWNE: That's pretty finite, one  
16 hopes.

17 MR. GILBERT: It gets more difficult  
18 with a chronic illness. Oncology being a very good  
19 example, what's the end point? So I think our group  
20 was well aware that the logistics of this are very  
21 very difficult. But we just, you know, felt that for  
22 some people that could be seriously disruptive.

23 MR. HIEPLER: The one thing  
24 logistically is whenever you're notified, and  
25 typically Martin's question, it's handled when a  
26 physician is decertified or disenrolled or something,  
27 immediately the medical group has to send and does  
28 send just for practical reasons a letter to the

1 patient and say, you know, "Now you got to choose  
2 from someone else, within 90 days you got to go to  
3 someone else."

4                   In that same context, the way that I  
5 think this can be taken care of logistically is at  
6 that time when they're disenrolling your specialist  
7 you tell them that his contract is up in this time  
8 frame; however, you can run to the end of the  
9 contract, whatever the end time is. And that's how  
10 we were talking about logistically handling this so  
11 that each medical group knows that that contract  
12 would typically end whenever it does. And they have  
13 that much time to try to finish up or switch to  
14 another medical group that does contract with that  
15 physician.

16                   Again, it lets the patient and the  
17 medical group take care of that and it gives them  
18 each an incentive to work for each other and get rid  
19 of a problem, especially you see this in oncology  
20 groups all the time, they change and a patient who  
21 has ongoing treatment with cancer has been with one  
22 doctor, they're left up in the air. And in that  
23 situation, at least it gives them to the end of the  
24 contract period as opposed to the 90-day period in  
25 which the time the doctor is being disenrolled.

26                   CHAIRMAN ENTHOVEN: I think we need to  
27 move to pressing comments on I.

28                   MR. HARTSHORN: I've got on I, what if

1 the doctor gets terminated, in other words  
2 voluntarily, did you talk about that? In other  
3 words, the doctor doesn't want to continue the  
4 contract.

5 MR. GILBERT: Though it was mixed, I  
6 think the feeling was if the physician made the  
7 decision to leave the group, then many of these  
8 things would not apply, if the physician was making a  
9 voluntary choice to remove themselves from the plan.

10 MR. HARTSHORN: And I assume if the  
11 patient agrees to move to a new physician?

12 MR. HIEPLER: Option.

13 CHAIRMAN ENTHOVEN: Bruce.

14 DR. SPURLOCK: A couple comments about  
15 continuity of care. I think it's a very important  
16 issue. I think it's therapeutic in many cases,  
17 especially with chronically ill patients. And I want  
18 to relate a personal experience I had with one of my  
19 patients afflicted with HIV and was dying. In the  
20 last six weeks of his dying process actually had his  
21 employer pull his care from my health plan, and I  
22 almost lost him. And I know personally in my heart  
23 what happens to a patient I was extremely close to  
24 when he was in his most difficult time in his life.  
25 It's a very important issue.

26 Having said all that, the  
27 patient-physician relationship is not the only trump  
28 cards. There are a lot of trump cards. Something --

1 an example I want to bring out with things that  
2 affect medical groups because medical groups have to  
3 deal with their colleagues and have congenial  
4 relationships with colleagues in their groups and the  
5 IPAs.

6                   There's questions of fairness when some  
7 members of the medical group aren't necessarily  
8 working at the same level as the others. An example  
9 could happen when open enrollment goes through and  
10 we're done with the contracting in a primary-care  
11 physician who typically has around 2,000 patients,  
12 loses all of his patients for whatever reason, then  
13 go to another health plan, they decide to go to  
14 another doctor, it comes down to one patient left, so  
15 they lose 1,999. And if they're going to make a rule  
16 that that medical group has to continue with that  
17 physician and the relationship or that one patient,  
18 there's huge interpersonal relationships within  
19 members of the group, and from a business standpoint  
20 it just doesn't make sense to have one physician in a  
21 medical group or IPA who is only seeing one patient.

22                   So there's real legitimate business  
23 reasons to have to play into this. So my suggestion  
24 would be to think about the concept of a threshold  
25 for maintaining chronically ill patients or something  
26 so if we get to the point where this really  
27 ridiculous number, you know, it's less than a quarter  
28 of the patients you have some left after some

1 contract year, that you wouldn't necessarily mandate  
2 that those patients stay on there.

3 So I think there's a threshold limit,  
4 even in PCPs, below that you cannot maintain it for  
5 business purposes.

6 Secondly, I think you also have to  
7 limit that continuity. My certain very important  
8 parameters and the one that comes up clearly is  
9 quality, so that if a physician is not maintaining a  
10 quality level or a new study saying that they need to  
11 perform 80 angioplasties and they're only performing  
12 20, that they can actually not have -- you know,  
13 maybe some of those patients enjoy that continuity of  
14 care, but the quality overall is not being maintained  
15 if there's this credentialing problem so that the  
16 physician has difficulty maintaining credentialing  
17 status for whatever reason that you would have those  
18 delimiters on continuity of care.

19 Finally, I want to talk a little bit  
20 about the termination issue. And I think a lot of us  
21 when we talk about the business reasons, it doesn't  
22 get to the heart of what the issue is with the  
23 physicians which is the "Why me?" So that if you  
24 have 100,000 less patients in your IPA after an open  
25 enrollment period and you have to terminate certain  
26 physicians, the question for most of those physicians  
27 is "Why me?" And a business reason is not good  
28 enough, and in fact, the way you settle that out is

1 in the courts. And so what happens with termination  
2 for cause even if it's for business reasons, it plays  
3 out in the court process and that there's no concept  
4 of fairness because we don't have a good way of doing  
5 that mechanism in the medical groups. So I think we  
6 want to make sure we have flexibility in the medical  
7 groups to be able to manage the business, to be able  
8 to flex up and flex down with changes in enrollment  
9 so that they can actually provide high quality  
10 adequate care.

11 And then we should always make sure  
12 that we have continuity to the extent possible and  
13 that we should support the patient-physician  
14 relationship because in the cases where everything  
15 else is equal, it's the trump card, but it's not the  
16 only trump card out there.

17 MR. GILBERT: We completely agree with  
18 the QAD credential issues. It wouldn't be applicable  
19 if you were to remove the doctor from the network in  
20 many cases.

21 CHAIRMAN ENTHOVEN: Okay. Ron  
22 Williams.

23 MR. WILLIAMS: Just a couple clarifying  
24 comments. Was it intended that the contractual  
25 arrangement that enabled the patients to extend to  
26 the relationship between the primary care physician  
27 or specialist and the medical group that's off of the  
28 IPAs or was it simply between the medical group and

1 the health plan? I just wasn't clear on that. Is my  
2 question clear?

3 MR. GILBERT: Are you talking about is  
4 it really more physician specific?

5 MR. WILLIAMS: Yes. Is it physician  
6 specific? The health plan maintain its relationship  
7 with the group? If the patient had a physician and  
8 left the physician in the group, that physician left  
9 the group, then what happens, I guess that's where  
10 I'm not understanding.

11 MR. GILBERT: As Terry mentioned, if  
12 it's a voluntary, if the physician's leaving  
13 voluntarily, then we don't see the continuity of care  
14 applying.

15 MR. GILBERT: Ron, we're looking at  
16 really a physician-specific relationship so that as  
17 an example, if a specialist was terminated for  
18 whatever reason and there was a member of the health  
19 plan of the medical group who terminated the  
20 physician who was in an episode of care with that  
21 particular physician that was felt to be significant  
22 enough that that relationship had to be maintained,  
23 then it would be either the health plan or the  
24 medical group's responsibility to cover the cost of  
25 that care until that episode of care was done.

26 MR. WILLIAMS: So from the patient's  
27 point of view, they're protected regardless whether  
28 it's an issue within the medical group or the health

1 plan or the medical group and the physician. Okay.  
2 Very good.

3 And the second question is: In terms  
4 of the more explanations and reasons we get into for  
5 nonrenewal, the more the issue of new entrants into  
6 networks will become a critical issue, that health  
7 plans will begin to say to new physicians coming out,  
8 "Let me go real slow in terms of determining whether  
9 I want to open up the panel to you and provide  
10 access."

11 So I think there are some tradeoffs. I  
12 don't quite know how to manage that, but that's one  
13 issue.

14 And I am concerned about the whole  
15 litigation question. I think it was put very well at  
16 the end of the day, the question is "Why me?" and I  
17 think unfortunately if you have fewer patients in a  
18 given geography, there often isn't a good way to  
19 figure out who you keep or don't keep.

20 MR. GILBERT: Just two comments, I  
21 think the latter part first.

22 I think it is difficult. I mean, just  
23 from my perspective of the fact that we have  
24 significant due process in some areas for physicians  
25 that go through peer review committees that still  
26 might make a determination that that physician should  
27 be terminated, and then they have rights of appeal  
28 through the system, you know, I think the question is

1 what are the applicability to some of those processes  
2 to the other side which unfortunately, as you're  
3 saying, might not be as well defined as a QA or  
4 another issue of that type.

5                   The new physician part is a good point  
6 because I think it goes back to Dr. Spurlock's point  
7 if I don't have the flex, I feel like I don't have as  
8 much flex, will I then not be as willing to take  
9 people on at the margin because I don't know if I can  
10 do the flex that you were referring to in terms of  
11 responding to the market. I think that's a  
12 legitimate concern. And somehow we were trying to  
13 figure out how to balance. Mark leaned over to me  
14 and said, "Well, we're just saying an explanation  
15 rather than for cause," but, you know, ultimately it  
16 will end up being treated as pretty much the same  
17 thing.

18                   CHAIRMAN ENTHOVEN: Helen.

19                   DR. RODRIGUEZ-TRIAS: Yeah. In this  
20 first part where you describe lack of choice and  
21 information, then, doesn't seem to follow with  
22 priority recommendation from the patient's  
23 perspective, making that initial choice when they  
24 become a member of a plan with very little  
25 information. I can just give it from personal  
26 experience not knowing the folks in the Santa Cruz  
27 area, how difficult it is without having any  
28 information that is like a doctor's profile, maybe,

1 I'm not sure what that minimal information should  
2 include, but something to the effect, you know, works  
3 well with older people or, you know, has a lot of  
4 experience, whatever.

5                   And the other piece of a choice is  
6 that, you know, I've been used to frameworks where  
7 you had teams practicing together and people who make  
8 these personal attachments, they're people that have  
9 better rapport with or less rapport with, or less  
10 experience like a younger doctor or older doctor,  
11 someone who is experienced with a particular age  
12 range with children. So where does that come in and  
13 where is that implemented for the patient?

14                   MR. GILBERT: The first part, I think,  
15 was addressed, I think, a fair amount by Jeanne and  
16 her group in terms of consumer information, trying to  
17 come up with a matrix of health plan selection that  
18 is actually useful and friendly. And so we sort of  
19 beg the question and we focused on the issue of  
20 making sure people understood the implications from a  
21 specialty access point of view because no one seemed  
22 to talk about that close panel, open panel.

23                   I'm sorry. I'm not sure I understood  
24 in terms of the rapport and relationship, I didn't  
25 understand the second part.

26                   DR. RODRIGUEZ-TRIAS: That patients  
27 make decisions after seeing physicians. And more  
28 informed patients are likely to be more demanding,

1 but there are people that will sort of hobble along  
2 with somebody, I don't know if that's a complaint or  
3 a grievance, and you have to route that person  
4 elsewhere so that they have somebody.

5 MR. GILBERT: So really looking at the  
6 issue of your ability to change PCPs once you've  
7 selected?

8 CHAIRMAN ENTHOVEN: I have to jump in.  
9 One thing just in order to get through this, one  
10 thing is this will be translated into a paper which  
11 then will come back to the Task Force for discussion.  
12 So everyone keep that in mind.

13 Next, I'm going to arbitrarily rule  
14 that Roman numeral II is sufficiently  
15 noncontroversial, that we'll get to Roman numeral  
16 III.

17 Now, Roman numeral III.

18 MR. LEE: Yes.

19 CHAIRMAN ENTHOVEN: Alpert and then  
20 Pete.

21 DR. ALPERT: My biggest fear, and I  
22 would hope that a number of other people around this  
23 table will share this, will be that we go through  
24 this whole process and make a number of  
25 recommendations and then, lo and behold, the  
26 legislature takes every one of them and unanimously  
27 passes them, puts them on the governor's desk, they  
28 all become law, and then everyone has thereby been

1 instructed to do something, does it perfectly, and  
2 nothing happens, the number of complaints stay the  
3 same, the ground swell stays or even grows more, and  
4 the number of bills, legislation that practices  
5 medicine which, of course, is an index of the failure  
6 of the system in terms of health that we're trying to  
7 help stays the same or increase because what that  
8 would say would be that we totally missed the boat in  
9 trying to address the issue that was causing the  
10 problems for us to exist.

11 MR. RODGERS: We just have --

12 DR. ALPERT: In the 171 days that this  
13 Task Force has existed, today is the second time I  
14 heard a very specific answer to the question of  
15 "What's the biggest problem causing all of this  
16 stuff?" And now as a disclaimer I decided not to  
17 talk to any of these people. I missed the meeting  
18 that they're talking about and so forth.

19 But if you look at No. 6, I'm talking  
20 about No. 3. But if you address -- if you agree with  
21 Mark and Brad and John and Bruce and myself as to  
22 where -- what venue the biggest problem is in which  
23 is basically once the patient wants to get care, goes  
24 to the doctor's office and those -- that process  
25 starts, if you believe that's where it is, and we put  
26 constructive recommendations and now we're getting  
27 more and more to that venue, I don't know exactly  
28 what the right ones are that we could digest all

1 that, but then you would probably eliminate No. 6  
2 totally because all of those problems which they've  
3 identified and they made recommendations for come  
4 about as a spinoff of all of this boondoggling that's  
5 taking place in the doctor's office where that  
6 doctor-patient arrangement is happening.

7                   So I'm thrilled to hear, you know, this  
8 answer. I would invite as we go on and hope we don't  
9 lose sight in our discussions in trying to answer  
10 this question, and I'm anxious to hear if anyone has  
11 another answer as to another place in the system  
12 where there's a huge component producing the  
13 complaints.

14                   CHAIRMAN ENTHOVEN: I think one of the  
15 big ones is the whole dispute resolution process. So  
16 you're sympathetic to Roman numeral III?

17                   MR. GILBERT: I would just point out  
18 the group is not in consensus on that.

19                   MR. HIEPLER: He likes the gold card.

20                   CHAIRMAN ENTHOVEN: Peter.

21                   MR. LEE: Having been advised of the  
22 shoehorn issues that are general to a topic, I have  
23 some specific comments as well.

24                   The doctor-patient relationship and the  
25 trust issue as an introductory -- Mark, you cited the  
26 CMA on it, but I think that sort of introduction is a  
27 useful introduction. I really appreciate it. I  
28 don't know if it might bias people's reading to cite

1 the CMA on it, but I thought that's an incredibly  
2 important point that I want to reenforce.

3 I was just thinking about the entire  
4 report what we're talking about is not a structure,  
5 we're talking about doctors, patients, other care  
6 providers, people who are sick, and trying to  
7 reenforce that and bring that home.

8 The other two sort of shoehorn issues  
9 is one you noted the nonpriority recommendation as I  
10 heard Brad's note on what the priority recommendation  
11 is one that is more likely to get consensus.

12 MR. GILBERT: No. I said the opposite  
13 actually.

14 MR. LEE: I didn't quite understood  
15 what "priority" meant.

16 MR. GILBERT: Priority is a combination  
17 of those things that actually the three of us could  
18 agree on, and two, what we saw as the highest  
19 priority, and three, potentially controversial. And  
20 we wanted to get them out there early rather than  
21 give our really easy one.

22 MR. LEE: Okay. On that one -- a  
23 couple that weren't on here, maybe they weren't  
24 consensus like the prior authorization is, I think  
25 it's very important for the ERG papers to include the  
26 prior authorization so that we as a whole can say  
27 let's do a straw pole, let's talk about that. And so  
28 I think this has been quite helpful. We have been

1 talking about prior authorization. But I would be  
2 very concerned that in the ERG editing process which  
3 Alain introduced earlier, the ERG products should put  
4 before the whole Task Force a range of issues, some  
5 of which hopefully will say, yep, we all agree, and  
6 some of which there will be incredible diversity of  
7 opinion on. We can quickly figure out that such a  
8 small minority agree with it, we don't need to talk  
9 about it, but I'd be nervous that that not appear in  
10 the ERG.

11 So that's a process note of what we'll  
12 see soon.

13 MR. HIEPLER: And the answer to that is  
14 that our two most important things happened to be  
15 edited out, and that's just because we didn't have a  
16 chance -- I was in court and he was running around  
17 with doctors when we got the draft and they just  
18 happened to be misplaced. That's why when I gave  
19 ours and he gave his he inserted his about  
20 authorization issue and I did the same.

21 MR. LEE: The other two points is, one,  
22 a note that I fortunately think we're going to need  
23 more than one additional meeting and many of the  
24 specific topics I think we're going to need time to  
25 talk about. That's a warning note.

26 The other is only to deal with overlap  
27 issues because a lot of these issues here do overlap  
28 and both as we discuss issues and also as we then

1 format the end report.

2                   And finally, the specific point is on  
3 page 2 at the top, "The purchasers encourage." I  
4 would like to see a recommendation that we discuss as  
5 a requirement related to something along the lines of  
6 standing referrals, maybe not permanent referrals for  
7 specialists for people with chronic conditions. And  
8 that's one of the things that I don't want anybody to  
9 be surprised that that's one thing I would like us to  
10 be talking about as well, for maybe not always have a  
11 specialist be your PCP, but have some process of  
12 maybe it's a year, maybe it's six months, maybe it's  
13 something different, but would actually be a  
14 requirement. So that's a heads up on that one. And  
15 maybe it will be in the ERG paper as well, but if  
16 not, I'll be bringing it up.

17                   MR. SHAPIRO: Mr. Chairman, I would be  
18 willing to yield from times of choice, seems like  
19 we're running out of time on this issue and I had  
20 several other comments and I'd be more than happy to  
21 yield.

22                   CHAIRMAN ENTHOVEN: Maryann.

23                   MS. O'SULLIVAN: Peter might have just  
24 covered what I wanted to talk about which was why --  
25 I was wondering why you let go of eliminating prior  
26 authorization, but Peter did sort of just get that  
27 back on the table.

28                   MR. HIEPLER: From a staff standpoint

1 it was edited out by accident. And from a discussion  
2 standpoint we had total agreement at least at the  
3 gold card level which I thought was a step in the  
4 right direction. And I had disagreements on prior  
5 authorizations, and I was, basically, shrouding  
6 myself to Dr. Spurlock and Dr. Alpert. And since it  
7 was recommended in another ERG, that's how it was  
8 edited out of this one.

9 MS. O'SULLIVAN: One way or another it  
10 will come back to us as a recommendation?

11 MR. HIEPLER: Right. That's on the  
12 boldness issue. And yet I think that the gold card  
13 thing is a step at least in the right direction.

14 CHAIRMAN ENTHOVEN: I commend you for  
15 being able to settle for steps in the right  
16 direction. That would help us. Yes.

17 MR. CHRISTIE: Yes. I'd like to  
18 comment on the subject of trust. Peter, I don't know  
19 where you were trying to shoehorn your discussion  
20 about trust between the doctor and the patient and  
21 this -- in this outline, but it occurs to me as  
22 Dr. Alpert well put it, the fundamental component if  
23 this whole discussion is without a doctor-patient  
24 relationship -- I had the occasion to be in the  
25 doctor's office a few weeks ago and I was dearly  
26 looking for a meter in the middle of his forehead  
27 that would describe to me in a particular medical  
28 condition whether he was giving me his best medical

1 judgment unhindered by some contracting between the  
2 IPA and him or he and the contracting HMO. And as a  
3 patient in one of the local clinics up in the Bay  
4 Area, when I go in I have to sign a form that's  
5 called a general consent form. And on that general  
6 consent form, I indicate that I will be willing to  
7 pay for anything that my HMO will not pay for and I  
8 will take responsibility for this and for that.

9                   Somewhere in this discussion I think we  
10 could eliminate a lot of our concern because I  
11 haven't heard the solution for the question yet today  
12 about the doctor-patient relationship trust if the  
13 doctor were to sign the statement saying that there  
14 is nothing about the contract that he has with his  
15 medical group or the contract that he has with his  
16 HMO that would in any way hinder his decision making  
17 ability in the case of my care. And I would like to  
18 throw that out as a possible item for this  
19 doctor-patient relationship issue.

20                   CHAIRMAN ENTHOVEN: Mr. Rodgers.

21                   MR. RODGERS: Just maybe an i.e.  
22 question, but authorization systems cost the health  
23 plans a lot of money too. If you look at whether  
24 it's a strong enough incentive to reduce the  
25 authorization process for the health plan to be able  
26 to say from the administrative side that without too  
27 much tinkering and more encouraging and modeling that  
28 the health plan would eventually come to that

1 conclusion that this is a way to also reduce their  
2 cost as well as the cost of the physicians,  
3 especially as capped rates are compressed and as we  
4 focus on the administrative cost.

5 MR. HIEPLER: Blue Shield has a study  
6 on it, they were one of the first. They would just  
7 say if you want to go to specialist, you would pay  
8 them a larger co-payment. And their analysis said  
9 that 90 percent of the time they approve it anyway,  
10 but it takes a long time to get to the committee and  
11 it's so costly that it's better to put a little extra  
12 money on the responsibility of the patient, let it  
13 go, and you avoid all those hassles. Then Aetna  
14 followed suit and others have. So I mean it's  
15 something that I think is going that direction just  
16 from a cost standpoint as you pointed out.

17 MR. RODGERS: So can we encourage the  
18 market -- when you're looking at your recommendation  
19 let's drive the market in this same direction because  
20 this seems like a good thing to do.

21 MR. GILBERT: The only other issue  
22 related to that is so much of the UR is done at the  
23 medical group level. They have specific -- at this  
24 point they're fully capped with a risk pool, they  
25 have very specific financial incentives to make their  
26 decisions. So I would agree with you at the plan  
27 level. I would also see those retrospective review.

28 But at the medical group level, I mean,

1     that's where my concerns are.

2                     MR. RODGERS:  It's still a cost to them  
3     though, as well.

4                     MR. GILBERT:  But they balance that  
5     cost off savings -- what they believe they balance  
6     those costs off savings from the risk pool and  
7     capitation, they believe that's a balance, I assume.

8                     CHAIRMAN ENTHOVEN:  Michael Shapiro.

9                     MR. SHAPIRO:  Just a brief comment  
10    tying the utilization review back to the termination  
11    issue.  I don't -- I'm a little bit worried about who  
12    gets the gold card.  One of the concerns we had in  
13    oversight is it seems to me that there is some  
14    pressure on physicians not to refer to specialists,  
15    not to treat even when they may deem it medically  
16    necessary because of the costs imposed on medical  
17    groups or the HMO.  I don't think any HMO or anyone  
18    who terminates a physician will say anything  
19    incriminating in that termination notice.  It's  
20    important to see the relationship preceding the  
21    termination for physicians to know about  
22    constructively critical concerns they may have about  
23    their referral process, about how they're practicing,  
24    so they can self correct that and hopefully avoid  
25    termination.  I think we are advocating for their  
26    patients who are in risk-adjusted pools who they have  
27    to refer more than the average, it is not those who  
28    are incompetent or those who are not needed for

1 business reasons because you have lost half of your  
2 population.

3                   So one of my concerns is to maybe  
4 consider economic profiling issues and all the  
5 material in SB 94 which is the pending bill so that  
6 you can ensure those who are getting gold cards or  
7 those who where given this responsibility are not  
8 simply those who are oppressed into denying care and  
9 therefore getting less by their HMO medical group for  
10 underserving, but are actually providing quality  
11 care. So I think there needs to be criteria  
12 associated with those who are responsible.

13                   MR. GILBERT: The concept is, of  
14 course, appropriate utilization, not being under or  
15 over.

16                   MR. HIEPLER: That was where the debate  
17 was and I thought the gold card was at least better  
18 than what you had, but that's why I think maybe a  
19 couple of us thought you could do away with it,  
20 follow the recommendation we had before, because if  
21 you eliminate the game plan over two years with  
22 picking out, you know, people that just don't treat.  
23 And that's a -- it's a real concern and especially  
24 from the patients' side when they're never getting  
25 out of a very closed network.

26                   CHAIRMAN ENTHOVEN: Maryann O'Sullivan.

27                   MS. O'SULLIVAN: I just want to raise a  
28 concern about relying too much on patients paying

1 co-pays as the way to deal with this problem because  
2 for the co-pay to be a bit of a chill and keep people  
3 from going to specialists too much, it's going to  
4 have to be pretty high. If you're talking say \$30  
5 for a co-pay, it means you're keeping a lot of people  
6 from exercising that and so we need other protections  
7 for people that can't afford the \$30 co-pay.

8 MR. HIEPLER: You were asking who was  
9 doing that, and I gave an example of Blue Shield as  
10 doing that as the market alternative. We're not  
11 saying that you should jack up the co-pay and then  
12 never get a referral.

13 MS. O'SULLIVAN: Right. Okay.

14 CHAIRMAN ENTHOVEN: Let me suggest, by  
15 the way, that members feel free to phone or fax the  
16 ERG group with their additional thoughts in some  
17 cases.

18 Let's go on to Roman numeral IV,  
19 financial incentives. This is disclosure.

20 I'd like to just offer a comment on  
21 this. I spent a great deal of time trying to  
22 understand what is the stated law because I thought  
23 there was a law that stated these incentives needed  
24 to be disclosed and I think there in Knox-Keene, and  
25 it's really a pathetic history, what happens is so  
26 many laws that their intent has nothing to do with  
27 what actually is carried out. It almost makes  
28 government look silly.

1                   And so I tried to understand why was  
2   it?  What -- you know, why wasn't that law carried  
3   out?  Well, it turns out health plans say we have 160  
4   or 180 or 200 medical groups or IPAs that we contract  
5   with and each one pays their doctors differently, and  
6   they think it's none of our business.  So it led me  
7   to feel in that case we really would have to go after  
8   the medical groups and IPAs, we would have to take it  
9   to that level, and I think that's something that  
10  we'll have to face.  There may be some resistance to  
11  that, but if we want real disclosure, it will have to  
12  go there.

13                   Then I had the feeling, you know, the  
14  disclosure that was made as someone read to me,  
15  anyway, it sounded like generic, not very helpful,  
16  not very meaningful statements.  I just wonder, here  
17  and in some of these others whether we could adopt  
18  the following thought.  And that is to say that  
19  within a year the DOC will have done a pilot project  
20  in which they randomly select 20 or 30 medical groups  
21  and IPAs, work out a model statement with them that  
22  they agree is a -- then send it to a sample of --  
23  representative statistical sample of members and ask  
24  them some questions like:  Do you understand this?  
25  Is it meaningful?  Is it helpful?  You know, and in  
26  other words, do some evaluation and put real time --  
27  this is not just pushing it off, put some real time  
28  limits on it, but try to get a few recommendations

1 for real pilot projects, and then say you will report  
2 back your findings and everything to legislature  
3 within two years or something like that. Would you  
4 feel that was a big watering down part if we --

5 MR. HIEPLER: Yeah. Completely. I  
6 would because it's clear people understand what their  
7 doctor's paid and how they're paid. And the problem  
8 right now is that even legislation states where you  
9 have a risk pool where you're sharing risks you need  
10 to disclose it.

11 What people understand is the  
12 fundamental amount that goes to their physician and  
13 if you do a statistical average, you're not  
14 protecting the patient who's going to a place where a  
15 doctor is getting \$5 and has every incentive not to  
16 refer and you're not giving that doctor credit for  
17 doing a great job on the \$5.

18 If you disclose the exact amount and  
19 for those services that are capitated, then you put  
20 the onus on the patient to understand.

21 CHAIRMAN ENTHOVEN: As to just doing  
22 some pilot test and some evaluation before we go  
23 through and incur all the cost and efforts to do it  
24 to see whether this thing works.

25 MR. GILBERT: We struggled with the  
26 issue, okay. Now you say disclosure. How do you do  
27 it and how is that information usable? Let me give  
28 you a specific example. DOC requires us to basically

1 have a set of policies that are available to the  
2 public about how prior authorization occurs. Because  
3 we're a health plan of many multiple groups, a big  
4 general policy of our standards tells the patient  
5 nothing about a specific instance with their doctor.

6 The only time they find out is if they  
7 file a grievance and we give them a specific reason  
8 why that particular referral -- if they get a denial  
9 letter, why that referral was denied.

10 So there's a difference between this  
11 broad disclosure that frankly is of no use to the  
12 consumer, a very specific disclosure that may be  
13 useful but where do you put it, how do you put it,  
14 how do you tell, and is it useful? I mean we didn't  
15 -- I mean notwithstanding, I agree. We have trouble  
16 figuring out how you deliver this information. Your  
17 point is maybe we can do a pilot to figure out how  
18 it's best to deliver.

19 MS. O'SULLIVAN: The way you can do  
20 that processwise is to be done everywhere within two  
21 years and can be figuring out the smart way to do it.  
22 But you want the mandate there so it's just figuring  
23 out the way to do it but that it definitely leads to  
24 something.

25 CHAIRMAN ENTHOVEN: Okay. Thank you.  
26 Maybe that would be -- that's a tough one to get,  
27 yeah, okay.

28 Michael Karpf.

1 DR. KARPFF: While we're developing all  
2 these instruments for disclosure to consumers can we  
3 make sure we make them available to our doctors  
4 because my own hospital, a busy PCP, is seeing maybe  
5 25 to 30 patients a day that may involve 15, 16  
6 different plans. The last thing he knows is exactly  
7 what plan that patient is working with. So I think  
8 if we walk out of here thinking that a doctor spends  
9 20 minutes analyzing each patient before he sees them  
10 as to how he's going to save a couple bucks on that  
11 patient, we're not understanding the way physicians  
12 practice.

13 CHAIRMAN ENTHOVEN: Michael Shapiro.

14 MR. SHAPIRO: I go back to my remark a  
15 few weeks or months ago when it was Oakland I forgot  
16 now where. There's something implicit about  
17 disclosing capitation, there's something wrong with  
18 it, or we can drive the market. People have choices  
19 to move from one plan to another. I'd feel more  
20 comfortable about disclosure. That choice is not a  
21 reality.

22 I go back, I'm not against disclosure  
23 but to the extent this group finds certain elements  
24 of capitation which would be against the public and  
25 certain extremes, certain intensities.

26 First and foremost, it would be nice  
27 for this Task Force to direct government or the  
28 industry to deal with those directly on behalf of all

1 consumers who do not expect fees based on disclosure.

2 CHAIRMAN ENTHOVEN: We have a physician  
3 incentives paper which will be looking at just that.

4 MR. SHAPIRO: I'm always worried that  
5 disclosure is going to substitute --

6 CHAIRMAN ENTHOVEN: That paper calls  
7 for direct discussion on limits.

8 Terry Hartshorn.

9 MR. HARTSHORN: Did you guys talk about  
10 the disclosure the fact most of the doctors in large  
11 medical groups, and Kaiser included, are on salary?  
12 So is the doctor going to say I make "X" for the year  
13 to the patient?

14 And then what about fee for service? I  
15 don't think if -- let's keep a level playing field  
16 here, if you're requiring disclosure on capitated  
17 amounts is the doctor going to say "For this visit  
18 I'm going to get \$20 for" --

19 MR. HIEPLER: Here's the situation,  
20 generally in a fee-for-service setting, even in a PPO  
21 setting, I'm going to see my bill. That's why when  
22 you argue what's known and what's not known, and  
23 correct me where I'm wrong because you'll know, if  
24 you have a fee for service you have -- you're seeing  
25 a bill and people always say, well, there's incentive  
26 to overtreat, but you know where the incentives lie  
27 in a capitated arrangement, you don't know as the  
28 patient where the incentives lie or don't lie.

1                   MR. HARTSHORN: There can be an  
2 arrangement between the health plan and the  
3 individual doctor and the medical group and the  
4 individual doctor on a fee-for-service basis. The  
5 patient wouldn't see the bill.

6                   MR. HIEPLER: Is that an exceptional  
7 circumstance? I understand that to be more  
8 exceptional?

9                   MR. GILBERT: Then that should be  
10 disclosed too.

11                  MR. HARTSHORN: What about the salary?  
12 I can't see doctors saying, "I make this much money."

13                  MR. HIEPLER: That's fact.

14                  MR. HARTSHORN: Well, the medical group  
15 might be getting the capitation, they break it down  
16 as salary.

17                  MR. HIEPLER: And that's real simple  
18 because if your doctor is a salaried physician in a  
19 large medical group, then the medical group discloses  
20 what their capitation is; however, low capitation  
21 gets disclosed. So if the capitated level is to the  
22 medical group, the patient needs to know what that  
23 medical group is getting for the cap rate.

24                  In the IPA model where it doesn't stop  
25 there, there's another cap rate even lower to a  
26 doctor, that's what you disclose. So wherever the  
27 cap ends, that's what you'll be disclosed.

28                  CHAIRMAN ENTHOVEN: Okay. Thank you.

1 We're going to have to move on.

2 MR. HARTSHORN: Since principal doctors  
3 are getting paid --

4 MR. HIEPLER: That's true.

5 MR. HARTSHORN: -- you're going to  
6 leave out a big chunk, then.

7 MR. HIEPLER: In a large medical group  
8 you go to a salary issue and I don't think that's  
9 actually reasonable to disclose what the salary is.

10 CHAIRMAN ENTHOVEN: Let me just take a  
11 straw vote. I'd just like to take a straw vote.  
12 What -- how many members of the Task  
13 Force favor the disclosure of actual financial  
14 amounts as opposed to a description of salary or  
15 capitation or fee-for-service or fee-for-service  
16 whether to withhold?

17 MR. GILBERT: There's a real clear  
18 methodology to disclosure.

19 CHAIRMAN ENTHOVEN: A clear methodology  
20 disclosure versus financial.

21 So if you favor financial amounts,  
22 please raise your hand. Pure straw vote just to give  
23 people an idea.

24 Three or four -- four. Okay.

25 MR. LEE: It depends which amounts you  
26 are talking about.

27 CHAIRMAN ENTHOVEN: That's just a  
28 suggestion that to think about the financial amounts

1 made, not to preclude it, but just an indication as  
2 to where this might go.

3 We're going to need to move on to the  
4 next topic. First we'll have a five-minute break for  
5 the court clerk and everybody else. Thank you.

6 (Recess.)

7 CHAIRMAN ENTHOVEN: Next we're going to  
8 have Rebecca Bowne and Michael Karpf presenting on  
9 academic medical centers and health care work force.  
10 Recall this is an ERG report so there will still be  
11 written documents to be sent in advance and then  
12 discussed by the Task Force, et cetera. So this is  
13 at an earlier stage of incubation.

14 DR. KARPf: I'll start off. I  
15 apologize for not having any written materials, I was  
16 out of the country. It took a little time for  
17 Rebecca and I to get our thoughts together, but not  
18 having written materials give me an opportunity to  
19 kind of reflect back. For the same reason as being  
20 out of the country, I didn't get a chance to read all  
21 the materials today, so it gave me chance to reflect  
22 back on some fundamentals.

23 It reminded me of the experience that I  
24 had that I think is kind of interesting and sort of  
25 gives me some insights into what I think are  
26 generalities we need to deal with.

27 There's a gentleman that was a patient  
28 of mine for many, many years and became a friend who

1 I view as someone who is a natural genius, who's a  
2 man who never graduated high school, and came back  
3 from the service to build a sand and gravel business  
4 he sold for \$80 million in the '70s. He got involved  
5 in the telecommunications when he couldn't spell  
6 "telecommunications" because he understood that there  
7 was going to be a need there. And he was one day  
8 riding behind an 18-wheeler and realized no one in  
9 this country sells axles for 18-wheelers, but he  
10 bought a big building, got a big press from Sweden  
11 and made axles for 18-wheelers. So he's someone who  
12 has lots of natural insights into needs and natural  
13 insights into circumstances.

14                   And he came out to visit in California,  
15 his son is in Indy car racing, so I went out and  
16 spent a few hours with him, he was very curious about  
17 what I was doing in health care. So I spent about  
18 three hours with him talking about what health care  
19 is all about, what the issues are. And after I gave  
20 this exposition he sat down and said, "Let me  
21 understand this, Mike. You're gone into a business  
22 where nobody wants to use the service. I've never  
23 seen anybody who wants to go into a hospital. You're  
24 going into a business where nobody wants to pay for  
25 this service. You know, people never paid for it in  
26 the past or paid very little for it, they don't want  
27 to pay for it now and the government doesn't want to  
28 pay for it. Mike, if you really want to try your

1 hand in business, start with me, and we'll do  
2 something that makes some sense rather than being  
3 involved in the business of health care."

4 And I think what he was saying is that  
5 really the issues that we are grappling with are  
6 issues of ability and issues of trying to resolve  
7 levels of expectation, what are reasonable levels of  
8 expectation and how do you, in fact, resolve them.  
9 And I think that's a dilemma that academic health  
10 centers found themselves in.

11 To understand that dilemma what I would  
12 like to do is spend a few minutes defining what I  
13 view as an academic health center describing how  
14 they've grown and how their growth over a period of  
15 time has led the problems that we have at academic  
16 health centers face in the managed care environment.

17 To me an academic health center is not  
18 a hospital, it's an entity, it's an entity that  
19 consists of a school of medicine, that may consist of  
20 other medical professional schools such a pharmacy  
21 schools, dental schools, schools of public health,  
22 and the entity also includes either a hospital or  
23 multiple hospitals and a variety of other services to  
24 provide health care to a number of patients.

25 These entities, and there are about 125  
26 or 140 academic teaching programs, have essentially  
27 three missions. And I think we need to understand  
28 those missions. The fundamental missions of an

1 academic health center are:

2                   One, education, the development and  
3 appropriate maturation of a work force.

4                   Two is research, both basic by medical  
5 research and translational research. Translational  
6 research is taking findings in a laboratory and  
7 bringing them to the patient bedside, essentially  
8 moving the level of care over a period of time. And  
9 our country is really at the forefront of  
10 translational medicine. All the development in  
11 transplantation, the complex heart surgery, the  
12 potential emergence of gene therapy, that really is  
13 all taking findings from a cellular level and moving  
14 them to a point where they can actually impact on the  
15 day-to-day lives of people that we know.

16                  And certainly service is a fundamental  
17 mandate and mission of academic health centers.

18                  And in service there are two types of  
19 services providing in the past in a more than --  
20 their proportionate way. One is high-end tertiary  
21 quaternary care service. Academic health centers are  
22 the places where the most complex patients with the  
23 most complicated diseases tend to end up. That's  
24 certainly part of their mandate, it's part of the  
25 skilled staff that they have.

26                  Many academic health centers also have  
27 to be participants in the safety net of health care.  
28 They've been there because they've either viewed it

1 as a responsibility or they've grown out of municipal  
2 hospitals, but that certainly they take care of more  
3 than their share of charity care and free care.

4 As we take a look at those three  
5 missions I think we have to realize that one of the  
6 problems we run into is that the funding for those  
7 three missions have been intermingled and commingled  
8 and have been indiscrete for a long period of time,  
9 and that's led to the dilemma that academic health  
10 centers faced in the managed care environment.

11 The reason the funding have been  
12 commingled isn't because that's the way academic  
13 health centers wanted it to be. It's the way  
14 academic health centers have grown over the last 15,  
15 20 or 30 years. This country had a fascination with  
16 science after World War II and particularly with  
17 biomedical science. The rapid growth of NIH fueled  
18 tremendous growth in the infrastructures of the  
19 medical schools and scientific capability and the  
20 interest of trying to move translational medicine.

21 This country also had a fascination or  
22 had a perceived need in the '50s and '60s of a  
23 physician shortage. There was a fair amount of  
24 legislation that was passed that spurred on the  
25 growth and development of the expansion of existing  
26 medical schools and development of new medical  
27 schools to fill this perceived lack of shortage of  
28 medical manpower.

1                   And in many ways indirectly the country  
2 chose to support its education and indigent care  
3 responsibilities through essentially caution  
4 shifting, using Medicare dollars and Medicare as a  
5 major source of support for education. Private  
6 payers kind of winked and realized that academic  
7 health centers were, in fact, using some of the  
8 dollars that were coming from patient care dollars  
9 for paying patients to take care of non-paying  
10 patients and take care of educational needs.

11                   And everything was great in academic  
12 medical centers until the mid '80s and late '80s when  
13 all of a sudden the ground rules changed, all of a  
14 sudden rather than there being lots of money  
15 available for research, lots of money available,  
16 direct or indirect, for education and some money  
17 available for patient care, the country took a turn  
18 and became much more accountable in terms of how it  
19 was going to deal with health care costs. They  
20 realized our resources aren't infinite for medical  
21 care, that one has to start developing a much more  
22 accountable system.

23                   And medical schools and academic health  
24 centers got caught as odd man out in that  
25 circumstance. They hadn't budgeted in a discreet  
26 kind of fashion. So with commingling of budgets for  
27 education, research, and patient care, they were  
28 found to be very extremely expensive and ended up

1 becoming the targets of payers and programs that were  
2 interested in trying to cut costs in health care.

3               So I think that for academic health  
4 centers we have to essentially, if we're going to  
5 allow them to survive, we're having to have to make  
6 sure that they have the opportunity and that they  
7 seize the opportunity to deal with the dilemma that  
8 they find themselves in a productive kind of way.

9               From my point of view I think all  
10 academic health centers have to understand that  
11 they're not going to be immune from the  
12 responsibilities of other providers in terms of being  
13 cost efficient, in terms of making sure that they  
14 respond to the marketplace and demonstrate in a  
15 quantitative way the quality that they say that they  
16 have and provide the services that they provide,  
17 whether they're tertiary care, quaternary care or  
18 primary, secondary care and as efficient mechanism as  
19 possible.

20              But we're also going to have to  
21 understand if we're going to hold them accountable in  
22 a cost effective way, we're going to have to make  
23 sure that they're budgeting for education and  
24 research becomes explicit so that, in fact, we can  
25 support those things that we think we want to support  
26 in a clear and appropriate kind of fashion, and  
27 decide in an explicit way what we don't want to  
28 support.

1                   So from my point of view I think as we  
2 look ahead and try to resolve the issues of how do  
3 academic health centers survive, we have to very  
4 specifically take a look at what they provide us and  
5 figure out what it is that is appropriate to support,  
6 what is appropriate not to support.

7                   One of the issues we've already dealt  
8 with, in fact, academic health centers are going to  
9 take care of the sickest of the population, the most  
10 complicated patients, then I think they're going to  
11 have to be recognized for taking care of those kind  
12 of patients, and issues of risk adjustment need to be  
13 addressed. I think this group has already made a  
14 major step forward in understanding that that is  
15 going to be a necessity.

16                  The issue of safety nets. I don't  
17 think that's an issue for us to deal with. If  
18 academic health centers are going to be safety net  
19 providers, there's going to be a squeeze put on them,  
20 that's a societal issue that the federal government,  
21 state government is going to have to have to deal  
22 with. That's not our responsibility.

23                  Issue of education and the work force.  
24 I think we all recognize that if there was a shortage  
25 in the '50s, we certainly overshot. There's probably  
26 going to be -- there is or will be a very substantial  
27 surplus of physicians. Not only will there be a  
28 surplus of physicians, but there's actually

1 maldistribution between primary-care physician and  
2 subspecialist, and there's certainly a  
3 maldistribution in terms of physicians in urban areas  
4 and rural areas. And so I think that that will have  
5 to be addressed.

6                   At the present time, medical education  
7 is rather expensive. At our institution we calculate  
8 that it costs us \$200,000 a year to train a medical  
9 student. It's a rather handsome sum of money. And I  
10 think most of the literature will suggest that cost  
11 per year somewhere between \$100,000 and \$200,000 per  
12 medical student.

13                   Medical education is supported in a  
14 variety of different ways. Much of it up until very  
15 recently it's still been supported very indirectly  
16 through Medicare, through GME and IME patient  
17 payments and payments for disproportionate share.  
18 Medi-Cal last year, for the first time in California,  
19 recognized some educational responsibilities and made  
20 a lump-sum payment to the University of California  
21 and is trying to recognize the need to support  
22 medical education over a longer period of time.

23                   I think we have to grapple with society  
24 as to how medical education is going to be supported.  
25 If it in fact is going to be supported by some  
26 payers, it probably should be supported by all  
27 payers. If it is going to be supported by all  
28 payers, I think that payers in society have a

1 responsibility to help define what the educational  
2 needs are going to be.

3 I think institutions like the  
4 University of California, like Stanford, like other  
5 academic medical centers will, in fact, if they ask  
6 and receive support for educational processes, will  
7 have to be responsive to the needs of the work force  
8 in the long-term.

9 So I think it will be incumbent upon  
10 the State of California to study and analyze and  
11 understand what its educational needs are, what its  
12 manpower needs will be for the future, and if it's  
13 going to support education, to use that support to  
14 help shape the medical manpower supply for the next  
15 generation.

16 So I would hope that we would be able  
17 to have a discussion on the support of education, if  
18 it's going to be explicit, if it's going to come  
19 through Medicare, if it's going to come through  
20 Medi-Cal, it probably should come through all payers.  
21 And I think that as part of that discussion I think  
22 we also can start framing a dialogue on defining the  
23 needs of California for medical manpower in the  
24 future.

25 I think by becoming explicit in  
26 funding, explicit in understanding needs it will  
27 become much easier to make the hard decisions that  
28 need to be made in terms of how many programs should

1 be supported, what kind of programs should be  
2 supported and whether those programs should be  
3 encouraged to train their physicians.

4                   The third issue that I think becomes  
5 very difficult and one I think that comes to the crux  
6 of many of the issues of managed care is how do we  
7 ensure that we as a society will allow and encourage  
8 academic health centers to continue to push the  
9 envelope of care. I think we're quite proud of the  
10 sophistication of our health system, we're  
11 disappointed the sophistication isn't uniform in  
12 terms of access, but we are proud of what we've been  
13 able to accomplish in taking science and making it  
14 medicine. I think all of us would be hesitant and  
15 concerned if we, in fact, weren't able to maintain  
16 that. If we couldn't look at our country and  
17 recognize that we are the leaders in the world of  
18 innovation in health care, of new approaches to  
19 disease, of making lives for critically ill patients  
20 better.

21                   There has to be some way of supporting  
22 that. It's one of the major rubs between managed  
23 care and academic health centers and expectations of  
24 a variety of patients.

25                   From my point of view, it becomes  
26 incumbent to develop some kind of system that is  
27 going to allow us to be able to do high-level  
28 clinical research in an effective kind of manner. I

1 think that as we get -- as we get more and more  
2 financially pressed, there is less and less  
3 flexibility to be able to support innovation without  
4 it being supported in a very explicit kind of way.

5                   Many of the conflicts that we see on  
6 whether a patient should be allowed to have a  
7 procedure, shouldn't be allowed to have a procedure,  
8 where we get in major disputes really revolve around  
9 the issue of is it an approved modality or isn't it  
10 an approved modality.

11                   We may have to come up with explicit  
12 ways of defining what is standard of care in complex  
13 patients or we may have to find ways of developing  
14 approaches of evaluating new methods of care in terms  
15 of whether they're effective or not effective.

16                   There are some models out there that we  
17 can look at. I think the federal government has  
18 recently tried to broach some of these issues. One  
19 of the models I think is particularly valuable is  
20 very quickly a new technique for the treatment of  
21 chronic obstructive pulmonary disease, it started  
22 becoming disseminated through the country as a  
23 surgical technique called lung reduction. It's very  
24 expensive. HICFA realized that if it didn't evaluate  
25 this technique, it would become accepted prior to any  
26 real information becoming available that would, in  
27 fact, in a scientific way define whether it was  
28 valuable or not valuable. So HICFA took it upon

1    itself to essentially say that we'll do a study.  
2    HICFA would put together a consortium of centers of  
3    excellence that would, in fact, evaluate lung  
4    reduction surgery, and if they could demonstrate it  
5    could work, they would end up paying for it in a much  
6    broader way.  If they couldn't demonstrate through  
7    the study that it really worked or really had some  
8    benefit to patients, either longevity or quality of  
9    life that was documentable, that it would have the  
10   latitude of not paying for this type of intervention.

11                   It's a very explicit approach to trying  
12   to evaluate cutting-edge technology rather than  
13   totally stopping it or totally supporting it without  
14   the appropriate data.

15                   So I would hope to be able to have some  
16   approach that we could support that would encourage  
17   all payers to deal in an organized fashion with  
18   allowing us to continue to develop cutting-edge  
19   technology, cutting-edge therapy, experimental care  
20   in terminal or critical diseases in a way that can  
21   evaluate those proposed new modalities in terms of  
22   effectiveness and appropriateness and make sure that  
23   we do not become a stagnant health care system and we  
24   maintain the dynamism that has made us the best  
25   health care system in the country -- in the world.

26                   So from my point of view, I think that  
27   there are three issues that we need to deal with  
28   in terms of the impact of managed care on academic

1 health centers.

2                   One, we've started to address in terms  
3 of adverse selection of patients and health --  
4 academic health centers taking on responsibility for  
5 those complex -- those complicated patients. I  
6 applaud this group for making this step.

7                   The other two issues of how are we  
8 going to support medical education, if in fact there  
9 are going to be continued pressures on academic  
10 health centers and they are going to have to be much  
11 more explicit in their budgeting. I hope we would be  
12 able to take on -- and if it is going to be done  
13 through a payer system, I think it has to be an all  
14 payer system.

15                   And I think we need to have some  
16 discussion of how we're going to be able to support  
17 the continued evolution of medical knowledge.

18                   MR. CHRISTIE: Of what, please?

19                   DR. KARPFF: Medical knowledge.

20                   Rebecca.

21                   CHAIRMAN ENTHOVEN: Thank you.

22                   MS. BOWNE: Ours was a little different  
23 in that we and Dr. Karpf obviously has great  
24 experience since he runs one of the top-rated medical  
25 centers in the United States, UCLA. I previously  
26 worked in an academic medical center, but we were  
27 largely using our own knowledge but responding to  
28 staff work. So ours was a little different, we were

1 sort of a response group. And Amy Youngman who is  
2 with us today, who works on Dr. Enthoven's staff, has  
3 drafted a number of proposals for Dr. Karpf and I to  
4 look at and to reflect on. So I'm -- we're not at  
5 all in disagreement, but I think maybe I'll bring  
6 some of it down to a little bit more practical level.

7                   And looking at the three components of  
8 education, research and patient care, I think it's  
9 clear that managed care is pushing for academic  
10 medical centers to become more competitive and more  
11 responsive. And yet I think in the remarks that  
12 Dr. Karpf has shared with us, and certainly in that  
13 of the testimony that we heard from the five -- well,  
14 actually the university system and then the five  
15 deans or quasi deans, for lack of other terminology,  
16 that spoke with us about the concerns of the medical  
17 centers.

18                   And the first area I would like to  
19 address would be the education and how many and what  
20 kind of physician training is going on in academic  
21 medical centers. And I think that there's, generally  
22 speaking, a feeling that the academic medical centers  
23 had at one point responded to the legislature that  
24 they would start restricting and slowing down the  
25 growth of the number of physicians both in medical  
26 school and in residency training. And we've not  
27 actually seen that happen.

28                   I suspect now that Medicare

1 reimbursement has explicitly in recent legislation  
2 formed a transition period to hold steady and reduce  
3 the number of medical school graduates and number of  
4 residencies. We may see some changes.

5 I think it would be important for the  
6 state to explicitly provide some transitional time  
7 and some transitional incentives. Specifically,  
8 perhaps there could be training at the residency  
9 level in managed care and ambulatory setting and  
10 particularly in under-served areas and under-served  
11 populations.

12 Without incentives, this isn't going to  
13 happen. I think that the government itself, the  
14 State of California, as well as through CalPERS, can  
15 use their leverage on purchasing power to negotiate  
16 with the academic centers to use their centers of  
17 excellence where they need to have support for the  
18 tertiary and quaternary care, that that would be very  
19 important.

20 By the way, still addressing the  
21 education issue and the cost of education. I think  
22 it's important, but not for -- for this group to  
23 recognize that it is up to the academic medical  
24 centers to look within themselves to examine the size  
25 of their training programs, meaning the faculty,  
26 their patient base, the number of residents that need  
27 to be trained, and it's a pretty sophisticated  
28 complication, but perhaps a suggestion from us to

1 look at that more closely with an eye to becoming  
2 more competitive and reducing their costs.

3 I was pleased with the testimony that  
4 we had from both Drew and USC about their strategic  
5 partners and alliances with community and ambulatory  
6 care centers. And I think that those kinds of  
7 alliances need to be emphasized, and again,  
8 incentivised. Because what happens is in the  
9 trainees when they get out in the managed care  
10 setting, in view of some of the managed care  
11 entities, they do not feel that they are prepared to  
12 do the primary care and ambulatory care that needs to  
13 be taken into account.

14 I don't know that Dr. Karpf got to this  
15 explicitly, but in the whole notion of the research  
16 we had talked about that on the basic sciences kinds  
17 of research, that is something that is not going to  
18 be paid for out of managed-care revenues. It's just  
19 something that's going to come from national  
20 institutes of health funding, perhaps, you know,  
21 various disease grants, that type of thing. And  
22 fortunately in California we get a significant amount  
23 of those research dollars.

24 But when it starts to make the  
25 transition from what we call the bench to the  
26 clinical setting that we should be looking for some  
27 ways that we could find in an innovative way that  
28 those costs could be shared because society as a

1 whole benefits from those. And we're not sure if  
2 that means, you know, all payers pay a certain  
3 percentage or there are specific government funds  
4 that are earmarked, but in that transition from the  
5 true bench research into the practical research that  
6 needs to be recognized that the academic medical  
7 center is where that's mostly to take place, and it's  
8 to be a specific society cost.

9                   And I want to echo Dr. Karpf's words  
10 when it comes to special kinds of experimental  
11 treatment, this is a problem where who gets the care  
12 and how is it funded becomes extremely difficult.  
13 And many of these cases take place in the academic  
14 medical setting because they're on the cutting edge  
15 of knowing how to do it, if not when and where to do  
16 it, what types of patients would have the opportunity  
17 to greater success.

18                   And we have to balance off here what  
19 we're perceiving as the need to be exploratory and  
20 yet you cannot answer the need of every patient who  
21 feels that they personally or their family member  
22 personally would benefit from an experimental  
23 treatment because in effect it breaks the bank and  
24 there just isn't enough money to go around.

25                   So the example he was giving with the  
26 lung resection and setting aside a specific amount of  
27 money and earmarking so that clinical criteria can be  
28 set up in an academic medical center as to who might

1 best benefit from this type of care and would perhaps  
2 be helpful.

3 We had, as a say, about a 45-page paper  
4 that we just sort of barely summarized for you, and I  
5 know that it's very difficult to react when you don't  
6 have anything in paper, so we probably need to get  
7 you a short version in paper of four pages.

8 CHAIRMAN ENTHOVEN: Okay.

9 Thank you very much both Michael and  
10 Rebecca.

11 Open up to the Task Force for questions  
12 and discussions.

13 Yes.

14 DR. RODRIGUEZ-TRIAS: Just a question.  
15 Is there anything in the pipeline on incentivising  
16 this redistribution -- better distribution of doctors  
17 in California?

18 DR. KARPFF: University of California  
19 has an agreement with the state through the Eisenberg  
20 Memorandum of Understanding to change its mix of  
21 trainees so that its mix, I think by the year 2001 or  
22 whatever, it is 50/50 primary care subspecialty care.

23 And there are benchmarks for every  
24 year. To date, University of California has met  
25 those benchmarks and has started reengineering its  
26 training programs to try to emphasize primary care  
27 and to deemphasize subspecialty care.

28 At UCLA in internal medicine we've

1 essentially committed to either primary care internal  
2 medicine or academic training so that we do not train  
3 cardiologists for practice, gastroenterologist for  
4 practice we train primary care internists or we train  
5 individuals who become fundamentally clinicians,  
6 researchers, individuals who are willing to spend two  
7 or three more years, oftentimes getting a Ph.D. in  
8 addition to their M.D. So I think there has been  
9 some progress at the U.C. level.

10 MS. BOWNE: I would like to say that if  
11 there has been progress, it hasn't been as well  
12 documented as it needs to be, and I would suggest  
13 that I think we need to push for that, not only  
14 documentation, but for the plan of orientation to see  
15 that it's followed through.

16 DR. RODRIGUEZ-TRIAS: The other issue  
17 is, you know, not just the training but where they  
18 end up after they're trained and where is that step  
19 that say the national health service corps and other  
20 incentive programs provided prior to this.

21 DR. KARPFF: Maldistribution in  
22 California is still a major problem so that we have  
23 large excesses of primary-care physicians and  
24 subspecialists in certain areas and very substantial  
25 shortages of primary-care physicians. But there are  
26 no mechanisms that I'm aware of that will address  
27 that at this point in time, and that may be a  
28 fundamental issue that we may want to comment on.

1                   MS. BOWNE: And one way to do that  
2 would be, for instance, through our Medi-Cal  
3 contracting in under-served areas to recognize that  
4 sometimes you need to pay a differential in an  
5 intercity or in a rural area in order to incentivise  
6 providers and health plans through the managed care  
7 system to be willing to practice and, you know, serve  
8 those particular populations.

9                   DR. RODRIGUEZ-TRIAS: And to provide  
10 the training opportunities, you know, good training  
11 opportunities and experiences for folks because  
12 that's how they become familiar with the system and  
13 willing to work them.

14                  CHAIRMAN ENTHOVEN: Tony Rodgers.

15                  MR. RODGERS: Yeah. Thank you. Having  
16 run an academic medical center in my life, I can  
17 appreciate the challenges that managed care creates  
18 for the academic medical center staff as well as  
19 administration.

20                  One of the realities that we came up  
21 with is the fact that the only way to reduce variable  
22 cost in the academic medical center environment is to  
23 integrate programs. And we found that a couple of  
24 things happened. It actually improves a residency  
25 program to have an integrated between say UCLA and  
26 USC, it reduces the overhead because you're not  
27 duplicating expensive faculty, you make better use of  
28 your fixed capital which is conference rooms, et

1     cetera, this kind of thing.

2                     However, the biggest problem, and I  
3     call it the university ego issue, is the willingness  
4     on the part of those directors to say my internal  
5     medicine program I will integrate with the UCLA or et  
6     cetera to reduce my costs so that I could become  
7     competitive, improve my residency program at the same  
8     time and allow for a center of excellence to grow  
9     within that residency program so that you're not  
10    competing against yourself, a UCLA with an open heart  
11    surgery program, a USC with an open heart surgery  
12    program, et cetera, the county with an open heart  
13    surgery program. You begin to integrate, and then  
14    you can have the best of all possible worlds.

15                    The question I have for the academic  
16    medical centers: What mechanism are you going to put  
17    in place to deal with the hard issue because it is a  
18    hard one to deal when you're talking about whose  
19    program survives to create the integrated delivery  
20    system that you need in order to be successful in  
21    managed care without pushing all the costs under  
22    managed care.

23                    And then number two, the other part of  
24    the problem is getting patients to go to the academic  
25    medical center. And when there's three or four of  
26    them competing against each other, plus you generate  
27    your competition by creating the specialists to go  
28    out in the community and offer the managed care

1 organization's lower-cost programs because they can  
2 compete against your fixed cost and say we can reduce  
3 the cost.

4                   So it's very complicated. But what's  
5 the mechanism that you think you're going to use to  
6 come to the conclusion for what's best for each  
7 region of California? Because it's going to be a  
8 different solution in each region as well.

9                   DR. KARPFF: I think in terms of  
10 participating in or developing integrated delivery  
11 networks, that's a marketplace phenomena. So I think  
12 that as you take a look at them as every academic  
13 health center in California are working very hard to  
14 protect their economic base through developing  
15 relationships either building primary-care networks  
16 of their own, leasing primary-care networks,  
17 consolidating with other hospitals, merging with  
18 other hospitals, there are a variety of different  
19 arrangements that different institutions are going  
20 to. That in and of itself speak to the issue of  
21 training programs at this point in time. So let's  
22 really focus more to access to patients for research  
23 and service needs.

24                   There are many -- there are more  
25 training positions in the State of California than  
26 California probably needs. So I think that at some  
27 point in time the way one starts developing a  
28 mechanism for calling out programs is you do it

1 through financial incentives. If, in fact, there is  
2 a support mechanism for graduate medical education  
3 that is explicit if there is -- will be a national  
4 trust fund -- and I suspect because Medi-Cal has  
5 recognized some responsibility of medical education,  
6 there will be some component for Medi-Cal -- if there  
7 is essentially a trust fund, a coordinated trust fund  
8 for medical education, the people who run that trust  
9 fund will have to make very explicit decisions on how  
10 many trainees they need, what kind of trainees they  
11 need, and develop criteria on which programs survive  
12 and which programs don't survive, and have those  
13 really based on shaping the work force and quality  
14 implications.

15 MR. RODGERS: You don't feel we can do  
16 that in California by creating our own review of that  
17 and enforcing the issue?

18 DR. KARPFF: Yeah, I think we can do  
19 that because I think we should be able to bring  
20 together a variety of support mechanisms for medical  
21 education that will always be less than everyone  
22 wanted, and since it will be less than everyone  
23 wanted, there's going to be some prioritization that  
24 has to occur. And I think it's probably time for  
25 developing that prioritization based on shaping the  
26 work force for the state, based on quality  
27 parameters.

28 Now, when we shape the work force, I

1 will be the first one to agree that we need to make  
2 sure that we have enough appropriately trained  
3 primary-care providers, but that's not the only thing  
4 we need to train. We certainly need to train the  
5 next generation of neurosurgeons and the next  
6 generation of medical oncologists who are going to  
7 push the envelope there. If we end up responding to  
8 the media pressure, not taking the long view, we may  
9 in fact short ourselves by medical researchers.

10                   So I think one has to be -- if one's  
11 explicit in understanding what you need, one can be  
12 more explicit about developing criteria. And I think  
13 there are programs that are in existence that  
14 probably shouldn't be in existence.

15                   MR. RODGERS: I guess just to finalize  
16 this, will you come forward with a recommendation  
17 that says within two years, let's say, you will have  
18 addressed this problem and addressed the legislation  
19 with a comprehensive solution. That's the kind of  
20 recommendation I think should come out of here.

21                   I don't think we have the answers  
22 because it's too complicated and the county's  
23 involved in their training programs and the private  
24 universities, but if there was a group that could  
25 focus on this and then give a report in two years and  
26 say this is how we should do this, that's what I  
27 would like to see.

28                   DR. KARPFF: That I think is a very good

1 suggestion. We will draft a suggestion that will  
2 speak to the issue of trying to size out and  
3 proportion the work force in an appropriate way and  
4 speak to how to try to support that educational  
5 process.

6 MS. BOWNE: I was taking your  
7 suggestion as broader than just the education and  
8 also addressing some of the programs.

9 MR. RODGERS: That's correct.

10 DR. RODRIGUEZ-TRIAS: Yes.

11 MS. BOWNE: I was -- I don't think it's  
12 just on the educational issue.

13 DR. KARPFF: Okay.

14 MS. BOWNE: And the other thing that  
15 Dr. Karpf and I discussed that we didn't bring out  
16 explicitly, but the academic medical centers have  
17 been forced by managed care to very, very much reduce  
18 their cost, reduce their staff and start shifting  
19 their emphasis. And I think you're seeing a number  
20 of discussions of consolidation among and between the  
21 various academic medical centers because of that. So  
22 we do have to give academic medical centers credit  
23 for that.

24 DR. KARPFF: It would be wrong to  
25 believe that academic medical centers have not  
26 responded to the pressure. At UCLA if one looks at  
27 the cost per day, cost per CMI adjusted case, our  
28 cost today are less in dollars than they were at the

1 end of fiscal year 1993 which means we've been able  
2 to absorb medical inflation for a number of years.

3                   Had we not done that, we would have  
4 been totally noncompetitive, we would have been down  
5 there with the dinosaurs someplace. So I think we  
6 have responded. But in terms of responding to  
7 commingling the budget, one takes a look at UCLA  
8 which is a medical school of national prominence,  
9 it's the school that has sixth in the country in NIH  
10 funding, so it has -- brings in \$180 million in the  
11 state in research funding, has very prominent  
12 training programs. From the clinical enterprise we  
13 move someplace upwards of \$55 million to support  
14 educational and research endeavors. When you take  
15 those dollars out and then you cost account our  
16 costs, they're really sort of at the median level.

17                   So academic health centers have  
18 responded. But the burden of helping support the  
19 infrastructure and the needs of education and  
20 research, primarily clinical, research is quite  
21 substantial.

22                   CHAIRMAN ENTHOVEN: See have Alpert and  
23 then Hartshorn.

24                   DR. ALPERT: I asked this question when  
25 we had the presentation by the five representatives  
26 of the universities, and I was surprised at the  
27 answer I got.

28                   At UCSF, two pediatric surgeons who did

1 all the neurosurgery, the surgeon that did virtually  
2 all, most of the breast surgery, general surgeon,  
3 left the university environment. Very very prominent  
4 internist left and these are all people I know and  
5 they said simply the constraints of the practice  
6 environment within the university was such that they  
7 basically just burned out and left.

8                   Now, in trying to separate what the  
9 reasons or trying to separate the issues of managed  
10 care induced the paranoia about what happened to  
11 University of Pennsylvania with regard to Medicare  
12 and everyone went around to universities being  
13 careful where dictating and some accumulation of  
14 insults that I saw at UCSF people.

15                   I'm just curious, have you seen that  
16 kind of morale decrease among the faculty of UCLA?

17                   DR. KARPFF: No. I think we have seen  
18 more moral decay in the community than we have at  
19 UCLA. The level of organization and the  
20 competitiveness of the institution I think has given  
21 some folks the sense that we're at least moving,  
22 whereas if your individual practice in Los Angeles  
23 which is an absolutely breathtakingly fast-changing  
24 marketplace, I wake up every day wondering what new  
25 has happened. As an individual practitioner it has  
26 become much more difficult than being part of an  
27 organized system. And in fact, we've seen a push for  
28 community physicians to join us.

1                   CHAIRMAN ENTHOVEN: Terry.

2                   MR. HARTSHORN: Yeah. You mentioned,  
3 Dr. Karpf, that you would hope that managed care  
4 would help pay for education. We have to figure out  
5 a way to do it, I agree with that. Would you have  
6 some specific recommendation in your final report?

7                   DR. KARPf: Well, we'll see if Rebecca  
8 and I can come to consensus. My own sense is that an  
9 all payer system is probably going to be appropriate  
10 since Medicare has been a major stalworth of payment  
11 for education and there will be decreasing dollars.

12                  Medi-Cal has stepped up to the plate  
13 this year and I believe is trying to figure out how  
14 to deal with the issues of medical education. So it  
15 leaves the private sector out there. And so either  
16 revamp education completely, say it's a public good  
17 and gets paid out of tax dollars or you say a couple  
18 of pennies or penny or two from every dollar or half  
19 a penny goes to medical education and you recognize  
20 that it's a capital investment because I think that  
21 revamping, revitalizing and restructuring the work  
22 force is a capital investment for the medical  
23 industry.

24                  MR. HARTSHORN: Yeah, well, I would  
25 agree, but it has to be done to the market demands.  
26 I think as it moves to the private sector, the  
27 private sector will say, "Don't keep producing."

28                  DR. KARPf: That is exactly right. He

1 who pays the piper, calls the tune. And so I think  
2 if it moves to an explicit budget and a trust fund,  
3 that trust fund should, in fact, have responsibility  
4 for modernizing and modifying the end product.

5 MR. HARTSHORN: Just one additional  
6 point with the hearings we've had on revising  
7 Medicare, HMO payments and that, I think other HMOs  
8 did it, PacifiCare looked at five states:  
9 Washington, Oregon, California, Utah and Texas and  
10 tried to take out, they might not have cleansed the  
11 data completely, but take out the superspecialty, you  
12 know, the transplants, things you didn't see in the  
13 community hospital. So we cut down to say the more  
14 bread and butter, but it's still provided in a more  
15 academic institution, and our costs were between 17  
16 and 20 percent higher than academic medical centers.

17 So, of course, our argument to congress  
18 when we turned in the papers was, "Well, we're  
19 already paying for medical education, don't cut the  
20 Medicare payments anymore."

21 So I think that's some of the issues we  
22 will have to struggle with. I'm not saying that data  
23 is totally accurate to the point.

24 DR. KARPFF: That's right. If you take  
25 a look at any academic medical centers, there are few  
26 that live strictly on quaternary care. If we were a  
27 quaternary care hospital at UCLA, we would have 100  
28 beds. We happen to be a 500-bed hospital. So we do

1 a lot of tertiary care and a lot of things that could  
2 be found at 30 or 40 other hospitals in the  
3 community.

4                   What has happened to us is as we have  
5 grown our managed care business, in over a three- or  
6 four-year period of time the contract business at  
7 UCLA Medical Center has gone from 30 some percent to  
8 52 percent of our business, so the contract business  
9 has grown dramatically. The level of reimbursement  
10 has gone down dramatically. Where we used to net out  
11 63 percent, we net out 49 percent. When you take  
12 those two together, the amount of reimbursement that  
13 we get for the same book of business for managed care  
14 based on our activity now compared to '93, \$60  
15 million less.

16                   So we've taken a big hit. That makes  
17 it that much less possible for us to subsidize  
18 education or clinical research.

19                   If we cost count ourselves taking out  
20 what we do to support clinical information and  
21 research, then our cost structure is much different.  
22 The argument that I'm making is if we're going to  
23 have those economic pressures put upon us, and we  
24 should, we have to be responsive to the marketplace,  
25 we cannot be insulated from the marketplace, then we  
26 have to become much more explicit on how we fund  
27 those activities. How do we fund the education  
28 piece, how do we fund the piece for making sure we're

1 innovative in health care.

2 CHAIRMAN ENTHOVEN: Michael, roughly  
3 what -- can you give us a dollar figure as to what  
4 you have in mind as to the minimum essential amounts  
5 to -- is that asking for a wish list? But what would  
6 you really need in order to solve this problem? Is  
7 this like \$60 million a year per medical center?

8 DR. KARPFF: Can't tell you now. That's  
9 something that staff could very easily do by taking a  
10 look. There are ways of getting that number, but  
11 it's not a number that I've ever calculated.

12 DR. ROMERO: Can I try it a different  
13 way. Per doctor, per medical student, I mean how  
14 much subsidiary would be necessary?

15 DR. KARPFF: It's -- I wouldn't  
16 calculate -- I would rather sit down and think about  
17 it a bit because it's not on a medical student basis.  
18 Medical education you've got two components, you've  
19 got medical students and you've got residency  
20 training, and both of those cost something. And so I  
21 think that one would have to develop a methodology.  
22 I don't think it would be -- methodology would not be  
23 as complex as risk adjustment, I don't think.

24 CHAIRMAN ENTHOVEN: Heaven forbid.

25 DR. KARPFF: Oh, I think it's doable and  
26 I think that one could take a look and see what is  
27 coming from the feds, what's coming from the state  
28 and where the shortfall might be.

1                   And I personally think that one way one  
2 shapes behavior is by incentivising. So whatever  
3 dollar is out there is probably going to be less than  
4 the aggregate than we spend right now, just a little  
5 bit less to move the system.

6                   CHAIRMAN ENTHOVEN: I'm just trying  
7 to -- thinking, for example, the State of California  
8 as an employer has saved a lot of money through  
9 managed care by leveling off the growth.

10                  DR. KARPFF: That is correct.

11                  CHAIRMAN ENTHOVEN: And so if we could  
12 kind of compare that to the public sector in  
13 California in general and say, now, how do those  
14 savings compare with what the needs of academia would  
15 be to make that up? Would there maybe be some way of  
16 recycling some of those savings back?

17                  DR. KARPFF: Well, University of  
18 California has functioned as a prudent buyer as it  
19 should, and it's done that at the expense of some of  
20 its medical students. There are only two of the five  
21 U.C. schools that provide large chunks of service to  
22 their local faculty and their student bodies, UCLA  
23 happens to be one. We took an absolute blood bath on  
24 the U.C. contracts. So you know, they didn't  
25 understand. It's a two-edged sword. They did what  
26 they thought was right for them. And it was, but it  
27 had consequences on us.

28                  CHAIRMAN ENTHOVEN: Right.

1                   Barbara Decker.

2                   MS. DECKER: You mentioned one of the  
3 academic medical centers roles is to provide the  
4 service through both the safety net and the high-end  
5 tertiary care. And I wondering, I didn't hear you  
6 mention, and I missed the presentation of the five  
7 academic medical centers, do you see there being an  
8 issue right now with the local facilities taking on  
9 more of those cases because of the pressures of  
10 managed care and the referrals are not coming to the  
11 academic medical centers that should have if we have  
12 a push in the marketplace that says I'm going to keep  
13 this case locally because of the way perhaps the  
14 economics are functioning, you don't get the  
15 referrals to that academic medical center that are  
16 appropriate, that need the interdisciplinary-type  
17 patient care.

18                  DR. KARPFF: I think absolutely. I  
19 think the more enlightened plans recognize the  
20 ability of doing it right the first time. So we may  
21 be seeing some shift back. But if you take a look at  
22 pediatrics, pediatric programs have been threatened  
23 because more and more local hospitals will pick up  
24 chunks of pediatrics that they shouldn't be picking  
25 up.

26                  It's competition not only among  
27 hospital providers but among physician providers.

28                  In Los Angeles, there's a real issue

1    that adult internists are taking care of pediatric  
2    subspecialty cases because they're being pressured so  
3    much in terms of volume and they need to keep their  
4    volumes up.

5                   MS. DECKER:  So are you anticipating  
6    including any recommendations about that or do you  
7    think that's something that the market has to  
8    address?

9                   DR. KARPFF:  I think the market has to  
10   address that.

11                  MS. DECKER:  As a plan sponsor I've  
12   been a big advocate for the concept of getting care  
13   at the right place, that makes sense.  But I haven't  
14   ever found a way, an effective way, I guess, to put  
15   it in a contract that you will ensure that the level  
16   of care is appropriate for each case and hold the  
17   plans accountable for that.  I guess I'd be  
18   interested if there would be other ways of doing that  
19   to ensure it takes place.

20                  DR. KARPFF:  I think the issue of  
21   centers of excellence is one that is immerging more  
22   and more.  We take a look at California, being  
23   relatively new to California, I was an absolutely  
24   astounded to find 40 open-heart programs and to find  
25   a large number of programs are doing 100 cases when  
26   the literature says we really have a technically  
27   suburb program you have to have at least 200 cases to  
28   have the right kind of personnel to run a good pump

1 team, to run a good ICU. And so I think the issues  
2 of centers of excellence may, in fact, be a mechanism  
3 to doing that.

4 CHAIRMAN ENTHOVEN: Next, Mark Hiepler.

5 MR. HIEPLER: I'll defer.

6 CHAIRMAN ENTHOVEN: You'll defer.

7 Tony.

8 MR. RODGERS: I just have one quick  
9 comment. When we're looking at the mechanism for  
10 subsidizing education research and care of the  
11 academic medical centers, it's real important that we  
12 look at the market drivers. If you give subsidies,  
13 you're going to have a different attitude than if you  
14 make an adjustment to capitation where the member is  
15 in essence still having the ability to vote by their  
16 feet, so to speak.

17 I really caution us in just saying well  
18 we need a \$60 million subsidy, et cetera, is we look  
19 at what we want the academic centers to do because we  
20 do want them to be part of an integrated system of a  
21 whole and we want to see the development of centers  
22 of excellence. We can do that with the market  
23 drivers that will actually make the system work  
24 better and have a stronger academic training program  
25 as well.

26 DR. KARPFF: I agree with that fully. I  
27 hear that a lot when I go to Washington. People kind  
28 of wring their hands saying you're just not feeding

1 me. That's just not the right approach. Medical  
2 centers cannot be immune from the pressures of the  
3 marketplace.

4 In my own institution, UCLA, some of  
5 our very best services that have evaluated how they  
6 take care of patients are the benchmark services in  
7 the country for the quality. They also happen to be  
8 the benchmark services for cost. So I think that's a  
9 critical approach in academic medical centers. And  
10 we're supposed to be data driven individuals can, in  
11 fact, affect that.

12 CHAIRMAN ENTHOVEN: Okay.

13 Hattie, did you have a question? Oh,  
14 Phil has.

15 DR. ROMERO: It's just a minor point,  
16 Michael.

17 The business schools often raise a lot  
18 of money through executive education.

19 Do medical -- do academic medical  
20 centers raise significant funds or play a significant  
21 role in medical professional continuing medical  
22 requirements and could they expand in that more?

23 DR. KARPFF: CMA has sort of been a  
24 fringe player. What it's done is the way some  
25 departments pick up some monies for -- small amounts  
26 of money for discretionary kinds of use.

27 You know, I think that staff suggested  
28 that maybe academic health centers could support

1 themselves by retraining physicians to make that a  
2 costly -- a new source of revenue. Well, to be  
3 honest with you, the subspecialist out there who is  
4 hurting isn't looking to be retrained. He's looking  
5 to dig a hole around himself and insulate himself  
6 from change for some period of time. So I personally  
7 don't see that as a source of significant income.

8 DR. ROMERO: Okay. Thank you.

9 CHAIRMAN ENTHOVEN: Thank you all very  
10 much. I think that will wrap it up. I especially  
11 thank our presenters Rebecca and Michael on academic  
12 health centers.

13 Now, we have -- oh, one thing I've just  
14 been informed that our premiums equaled our outlays  
15 on the lunch. Thank you very much.

16 All right. We have now two presenters  
17 from the public who want to talk about the academic  
18 medical center expert research, but then we have two  
19 others. I think we'll do the academic medical  
20 centers then I want to talk about the Task Force just  
21 where we are with respect to our work and what we'll  
22 do next.

23 So is Nell Woodward of the California  
24 Dietetic Association still here?

25 MS. WOODWARD: Yes. But sequencing the  
26 other lady should go first.

27 CHAIRMAN ENTHOVEN: Oh, all right.

28 Teresa Bush.

1                   Thank you very much for appearing. I'd  
2 be grateful if you could make your remarks very  
3 concise.

4                   MS. BUSH: Good afternoon, almost  
5 evening. My name is Teresa Bush-Zurn. I'm a  
6 registered dietitian. I'm representing the  
7 California Dietetic Association, and I'm a Vice  
8 President of our education council.

9                   I came here today because, first of  
10 all, academic medical health centers work force we  
11 felt that registered dietitians are members of that  
12 work force and we educate them, so we felt that this  
13 is where we should come and testify. However, that  
14 has not been mentioned. But I brought you  
15 information, anyway, which I would like to share with  
16 you and maybe it would go under the -- there's  
17 another one -- there's a health care, professional  
18 health care, so I'm not sure which one, but  
19 definitely there are many members in the health care  
20 work force.

21                   This piece here that I passed out, the  
22 brochure, describes what a registered dietitian is  
23 and how we are trained and that -- and we work in  
24 health care, numerous areas in health care.

25                   And there's a Business and Professions  
26 Code which specifies what our education and training  
27 is. And just to mention that the dieticians have  
28 bachelors degrees in nutrition, they have 900 hours

1 of supervised practice is required, and they work in  
2 accredited institutions, they work in institutions,  
3 the training is in other hospital settings, not only  
4 academic, the definition of academic medical centers  
5 that was just mentioned a few minutes ago.

6 I wanted to share the impact of managed  
7 care and dietetic education programs and I passed out  
8 a handout to you, "California Dietetic Associations"  
9 is at the top of that.

10 And I surveyed the different programs  
11 in California that train dietitians and dietetic  
12 technicians who work with dietitians. There are 29  
13 supervised practice programs in California. 79  
14 percent responded with 20, which is 23, and basically  
15 the findings to questions. And we asked if  
16 supervised practice programs have lost affiliations  
17 which is training sites as a result of managed care  
18 plans, and I received a 43 percent "yes" response to  
19 that, and the comments are listed there for you.

20 Most overwhelming responses related to  
21 downsizing and restructuring and preceptors feeling  
22 they don't have time to educate.

23 The other things that are listed there,  
24 and I do wish you would refer to them. We also --  
25 one program was just recently closed this year, one  
26 internship program.

27 Second question: Has the number of  
28 students you accept into your dietetics program

1 changed as a result of managed care plans? And 83  
2 percent of the programs have kept their enrollments  
3 stable; however, not without a struggle. So they're  
4 struggling very much with that.

5 And I also want to --

6 CHAIRMAN ENTHOVEN: Could you please  
7 summarize now.

8 MS. BUSH: Okay.

9 My recommendation is that also you can  
10 save money. It doesn't cost to train dietitians. I  
11 actually -- you can see it's equal to two FDEs on the  
12 return of the investment that we receive. And I  
13 think to enable California's dietetics education  
14 programs to meet the growing demands of dietitians  
15 and technicians, managed care organizations much  
16 encourage the maintenance and expansion of supervised  
17 practice settings for dietetic internship and our  
18 educational process.

19 CHAIRMAN ENTHOVEN: Thank you very  
20 much.

21 MS. BUSH: Uh-huh.

22 CHAIRMAN ENTHOVEN: Next, Nell  
23 Woodward.

24 MS. BOWNE: Just for comment on that,  
25 Alain, I think that managed care settings generally  
26 want to provide practice settings, you know, for  
27 training of various kinds of professionals. And  
28 certainly one of the comments that Terry Hartshorn

1 was saying how is this going to be funded. If this  
2 is going to be funded through an effected task on all  
3 the insurers and managed care plans, I think they'll  
4 have even more to say about that.

5 CHAIRMAN ENTHOVEN: Right. Those who  
6 are paying the piper will want to call more than the  
7 tune. Okay.

8 Ms. Woodward, I apologize for being so  
9 brutal, but we really do need to ask each person --  
10 we will read the materials, by the way. I promise I  
11 will study them on the plane on the way home.

12 MS. WOODWARD: I don't know how you get  
13 them the same material, anyway.

14 CHAIRMAN ENTHOVEN: We'll mail it.

15 MS. WOODWARD: I'm Nell Woodward. I'm  
16 a registered dietitian, and I'm here as a  
17 representative of the association. Currently I serve  
18 as a delegate to the National -- the American  
19 Dietetic Association. I'm a retired long-term  
20 community college educator. So my life history has  
21 been an intertwining of dietetics and education.

22 I just wanted to say that the number of  
23 opportunities for dietetic students to gain  
24 supervised practice positions is, therefore, of great  
25 concern to us as an association. So I thought the  
26 succinct way of showing this to you is through some  
27 data. If you look at the front page with the  
28 enrollments, you'll see we first have a preliminary

1 dietetic program, the second space is the supervised  
2 practice, and over on the right side across from  
3 internships you see that we have potential graduates  
4 each year of 157 to 170 and under coordinated  
5 undergraduate programs, 28 to 48, taking a midpoint  
6 we have roughly 200 dietetic entry-level  
7 practitioners every year.

8 MS. BOWNE: Excuse me, is this for  
9 California or national.

10 MS. WOODWARD: This is California,  
11 yeah. Up at the top I say for "Practitioners in  
12 California."

13 We also have some advanced degree  
14 programs which, although they are not designed to be  
15 entry-level, practitioners do output about 10 per  
16 year, so our output in dietetics is about 210  
17 students.

18 We also have the two-year associate  
19 degree graduate technician and in that program we  
20 have about 108 graduates.

21 Turning the page, we ask the question:  
22 Well, how many do we need? Because it's  
23 irresponsible to train more people, I believe  
24 personally, than what we need. So one of the major  
25 sources --

26 CHAIRMAN ENTHOVEN: We agree with that.

27 MS. WOODWARD: Thank you.

28 -- is to look to the California

1   Employment Development Department, and I have done  
2   some research studies with them. So this data is  
3   readily available to me.

4                   Using the OES code for dietitian and  
5   nutritionist, and Terry didn't mention that in  
6   California although dietitian has a decidedly legal  
7   term or connotation, nutritionist is very open ended  
8   from zero to Ph.D. So that's a tough term.

9                   But taking their projected figures of  
10  absolute change on the top line there of 1250 and  
11  dividing it by the 15 years interim, and then doing  
12  the same for separation and openings, you see bottom  
13  line is that we need -- well, we need about 179  
14  according to that data.

15                  I have for you there the results of a  
16  study I did in Orange County comparing known dietetic  
17  professionals, qualified, educated and employed, and  
18  I found out that they work under different job  
19  titles, in different job settings and are often  
20  self-employed. So EDD does not capture them. And  
21  looking at the numbers in the study that is available  
22  should you wish it, we can at least increase EDD data  
23  requirements, demand requirements, by 50 percent;  
24  hence, the number that is needed annually is -- I  
25  can't find it right there, 268.

26                  In contrast, technicians are over  
27  accounted for EDD and we don't have that many  
28  employed. But there again, that's not a legal title

1 and a lot of people serve in that role.

2                   So my recommendation that managed care  
3 organizations must maintain and expand supervised  
4 practice studies of dietitians and technicians so  
5 that we could get the right number and that we not  
6 only maintain but meet the projected demands for  
7 California. Thank you.

8                   CHAIRMAN ENTHOVEN: Thank you very  
9 much. Thank you.

10                  MR. LEE: Just -- not a question, just  
11 a general comment. I appreciate you coming to  
12 testify.

13                  One that came up in the context of the  
14 physician-patient relationship is that we need to  
15 make sure we don't lose all the "X" patient  
16 relationship players. And one you testified about,  
17 the changing composition of nursing care and our  
18 hospitals having nursing aides instead of registered  
19 nurses and what are the implications of that. And  
20 it's -- I am not sure exactly which ERG some of these  
21 things fit in, like this recommendation which I will  
22 certainly think about as a Task Force, well, we've  
23 got good headings, some things are not going to fall,  
24 and the nursing-patient relationship's another one,  
25 that we could have an ERG called "nursing-patient  
26 relationship," but that's a reminder for us to, as we  
27 look over our notes, et cetera, to make sure we don't  
28 lose this.

1 MS. O'SULLIVAN: This morning the  
2 gentleman testified on mental -- the imparity on  
3 mental health. And I don't think that's come up  
4 anywhere. I think we need to talk -- think about how  
5 to address that whole range of things that we're not  
6 going to address, probably, especially since we have  
7 had all this hoopla that the governor's waiting for  
8 all this.

9 MR. LEE: Just a reminder,  
10 Al, with the next meeting on the 28th, we should have  
11 a block of time to try to capture those. So between  
12 now and the next meeting us Task Force members should  
13 see what some of those issues are. Isn't that  
14 correct, Al?

15 CHAIRMAN ENTHOVEN: Yes. That's  
16 correct. I will say, though, that people who propose  
17 we undertake more topics will have to be ready to do  
18 a lot of the research, find the sources and so forth,  
19 because the fallout from these meetings is going to  
20 be an enormous strain for my group. We're already --

21 MS. O'SULLIVAN: My proposal is that we  
22 don't address all the questions, but that we keep in  
23 mind as we're framing the report that we're not  
24 addressing them all so that it's not saying we did  
25 not address it, we didn't think it was important.

26 CHAIRMAN ENTHOVEN: I think the  
27 question with mental health parity, for example, is a  
28 discussable topic, but I would question whether that

1 is specifically a managed care issue as opposed to an  
2 all health insurance issue. Now, you know, some  
3 people say, well, at the second order managed care  
4 might help or hurt, managed care might make it more  
5 affordable, for example.

6 MS. O'SULLIVAN: What are the numbers?  
7 Like 95 percent of the people in California are in  
8 managed care. It sort of becomes a managed care  
9 issue. I'm fine if we don't do it.

10 CHAIRMAN ENTHOVEN: Now we have Maryann  
11 Schultz, American Nurses Association of California

12 DR. SCHULTZ: My name is Dr. Maryann  
13 Schultz, and I represent the American Nurses  
14 Association of California.

15 While remaining sensitive to the  
16 economics of and the utilization of physician  
17 preparation, there are other health-care providers  
18 who are essential for the system. One group as  
19 nursing and managed care is associated with a slower  
20 employment for hospital nursing and subsequent shift  
21 of their employment to other non-hospital settings.

22 And because we believe that nursing  
23 care is an essential part of both the sick care and  
24 the health care system, we respectfully suggest these  
25 two things: Advanced practices nurses maintain or  
26 improve selected patient outcomes. And there  
27 exists a real good database in the State of  
28 California that speaks to supply and demand issues in

1 nursing in another state line Task Force.

2                   So we would request that you work with  
3 the American Nurses Association of California or I  
4 think there would be ready and able volunteers as you  
5 suggest to help with the fallout that would occur  
6 after each and every large meeting such as this to  
7 include not just physician preparation but the  
8 preparation of other care providers including nursing  
9 and other service providers in your bigger picture  
10 which would be in keeping with the Health Professions  
11 Education broader statement in your task, I think  
12 it's No. 5, and I think that's all I have to say.

13                   I personally would be willing to  
14 volunteer for the organization on behalf of the  
15 organization because I know you can't just dictate  
16 that people take on more. And I thank you very much.  
17 We will forward our remarks next week.

18                   CHAIRMAN ENTHOVEN: Thank you very  
19 much.

20                   MS. BOWNE: Were you speaking to -- it  
21 sounded like the issues that you were bringing up to  
22 us which we have had testimony from nurses before too  
23 was really speaking to the slower employment in  
24 hospitals and the substitution for other care givers,  
25 if you will, rather than registered nurses.

26                   Did you have any comments on training  
27 of nurses and the training programs for nurses as  
28 they relate to managed care?

1 DR. SCHULTZ: Yes. Those were  
2 background remarks that just indicated managed care  
3 in the nation as a whole. And in California when  
4 managed care enters the marketplace in health care we  
5 see a slower employment growth rate in hospitals that  
6 shifts to the non-hospital setting.

7 With stair stoppers available to train  
8 and retrain existing nursing or physician groups I  
9 think it's critical that nursing and physicians and  
10 the other groups dietary and so on, rather than in a  
11 completely adversarial sense complete for stair  
12 stoppers to retool that existing nursing work force  
13 as opposed to train and retrain physicians and other  
14 groups.

15 There might be a way for us to approach  
16 the problem, and I would love to see your group  
17 include some of those ideas and some of the data that  
18 exists in California on the issue which I will  
19 forward.

20 MS. BOWNE: Because one of the issues I  
21 think that comes up is the pattern of care for the  
22 future is much more of team care which there would be  
23 nutritionists, therapists, nurses, as well as  
24 physicians. And I think the issue probably does need  
25 to come into play a little bit are today's academic  
26 medical centers aware of and geared up for the kind  
27 of integrated team patient-oriented care that may be  
28 needed in the future. So that's --

1 DR. SCHULTZ: When I forward my remarks  
2 I'll bear that in mind and address that issue.

3 CHAIRMAN ENTHOVEN: I appreciate your  
4 characterization as a slowing in the growth rate of  
5 nursing employment in hospitals because so often we  
6 hear from providers talking about drastic cutbacks  
7 and slashes and when we look at the data we find  
8 there hasn't been a cut back, it's merely slowing of  
9 the growth rate.

10 California public policies recently put  
11 out a report on nursing employment and hospitals and  
12 found that it had grown rapidly up to about 1993 and  
13 then became essentially flat. So it didn't -- it  
14 hasn't been cut back anyway, it's just the growth has  
15 stopped.

16 DR. SCHULTZ: Thank you for  
17 acknowledging that. In a dissertation I completed at  
18 UCLA recently I like to mention the works of  
19 Dr. Barenhouse and Dr. Ianhoven. When I read those  
20 things they teach me to use my vocabulary properly,  
21 especially in --

22 MS. SKUBIK: This might be a good time  
23 to mention that I the California Research Bureau  
24 doing a mapping of nursing and physician supply  
25 across the state, it should be available to you.

26 CHAIRMAN ENTHOVEN: It's in the packets  
27 today. Excellent.

28 Now I'd like to move -- before we hear

1 the last two speakers I just would like to move to a  
2 brief discussion of what I'm thinking about anyway is  
3 to where we go. We had on the schedule two other  
4 papers for discussion, the balancing of private and  
5 public sector roles and discussion of the  
6 standardization of benefits paper which will have to  
7 be rolled forward to discussion at the next meeting,  
8 and that's what I propose to do. It's just as well  
9 with the balancing of private-public sector roles  
10 because I think perhaps I'd like to do a little more  
11 work on that.

12                   Let me just say about that that this is  
13 an attempt to pretty much, you know, avoid hot  
14 buttons and to go down the middle on describing what  
15 is. And part of where the paper started was back in  
16 June John Eichart asked me to present with Sara, a  
17 health care conference on regulation, and he said,  
18 "We want you to come and make your case for  
19 premarkets." I said, "Well, John, I can't honestly  
20 do that, there are just a lot of things for which we  
21 have to have rules." I mean just for example on the  
22 emergency care and the reasonable person standard for  
23 contracts to work, for market to work you have to  
24 have a lot of things that some people call consumer  
25 protections, other people call it accuracies,  
26 specificities, you know, there's just a whole lot of  
27 stuff the government does in every industry that just  
28 to support and rules of the game to make it work.

1 And that has to be the case in health care and in  
2 space in fact, because we have all these things where  
3 we aren't sure, adverse selection, complexity of  
4 contracts, et cetera, et cetera, et cetera.

5                   So we will try to write a description  
6 of, you know, where we think it has to be which is  
7 meant to be pretty much a description of where we are  
8 now.

9                   That the meeting of Leonard Shaper of  
10 Blue Cross says, oh, God, this sounds like a complete  
11 government takeover. I said, no, I don't think it's  
12 asking for more regulation but it's explaining the  
13 regulation that we have. You know, kind of a  
14 logical, conceptual basis. So the paper isn't meant  
15 to push things one way or another. I think that, you  
16 know, the Task Force is working in the realistic  
17 framework based on the maximum incremental limits is  
18 one of the first laws of democracy and where we  
19 take where we are and then figure out what are some  
20 feasible steps forward from there.

21                   So I'll do a little more work on the  
22 paper. I apologize it went out in a hard degree form  
23 and we'll send out a somewhat cleaner version of  
24 that.

25                   The other one on the standardization of  
26 benefits that might go the way of risk adjustment.  
27 I'm consciously optimistic. As I think everybody is  
28 aware, health insurance contracts are complex. I

1 mean, real expert experts, I mean, on a scale of one  
2 to 10 if you say the Knox-Keene Act is a 10 in  
3 complexity, health insurance contracts are at least a  
4 three or a four, very complex.

5                   And what major purchasers have done  
6 like CalPERS, for example, and PBG in Stanford is to  
7 say a lot of variation in contracts from one to  
8 another is really hard reading comparison and they  
9 have gone to standardization and said to all of their  
10 HMOs anyway this is the contract we want to buy from  
11 you.

12                   And that has enormously simplified  
13 things. I push it through at Stanford as chairman of  
14 that to get this thing simplified enough that even  
15 the professors could understand it. So it's an  
16 explanation of why standardization and then some  
17 cautious recommendations about how the state could,  
18 and DOC could, help in the small-group market by  
19 helping to develop some responsible, what we call  
20 reference contracts that would be out there that  
21 parties could use without further approval. It  
22 wouldn't limit their freedom if they wanted to have  
23 some exotic contract, but at least a small employer  
24 could say to insurers I want your quote on standard  
25 plan A. So I think that's what that ones about.

26                   MS. BOWNE: Alain, are you willing to  
27 entertain, and should we send directly to you, people  
28 who plan on disagreeing and have some suggestions?

1                   CHAIRMAN ENTHOVEN: Yeah. Provided you  
2 won't get me back. Well, the recommendations are  
3 meant to be cautious, but I think it would be wise  
4 for me if you would fax me on Monday a record with  
5 your notes on paper, I would be happy to consider  
6 those very carefully. And we'll take it from there.

7                   MS. BOWNE: I think I'll just get to  
8 the issue that while standardization can help ease of  
9 understanding it can also limit, severely limit  
10 innovation and flexibility, and that what happens  
11 when you start into that is that you very very  
12 quickly get into the whole issue, of you know, what's  
13 minimum, what's mandated. And then before very long,  
14 particularly for small groups, you have a package  
15 that while worthwhile was so expensive that many  
16 can't afford it.

17                  CHAIRMAN ENTHOVEN: This would can be  
18 voluntary. Two, I would expect that the development  
19 would produce a range from something absolutely bare  
20 bones and minimal if the employer wants that to  
21 something more comprehensive, but it would be  
22 voluntary. But please send me your comments.

23                  Okay. I think that that clears the  
24 decks now to go to our last public commentator and  
25 then we'll be able to wrap up pretty much on schedule  
26 and we'll roll these papers or a slightly revised  
27 version forward to the next meeting and what we're  
28 going to have to do is constant kind of rolling

1 revisions of the schedule as we see where things are  
2 or some of the papers develop faster than others and  
3 so forth.

4 Barbara.

5 MS. DECKER: What's your expectation  
6 now since we talked -- we did two background papers  
7 and we did the one about risk adjustment, now do we  
8 literally think we'll vote on those three at the next  
9 meeting?

10 CHAIRMAN ENTHOVEN: I'm hoping that on  
11 the two background papers and risk adjustment we will  
12 send you a week before the meeting a version that has  
13 been revised to take account of the discussion to the  
14 best that we can do. And then that will be put forth  
15 to the Task Force.

16 And in the case of the background  
17 papers, does the Task Force adopt this as its  
18 response to the legislative mandate? And in the case  
19 of the risk adjustment, we'll vote recommendation by  
20 recommendation. We'll make them severable so you can  
21 be in favor of one and against two and so forth.

22 Now, let me say, you know, as I reflect  
23 on the discussion of background papers this morning  
24 and the demands of the schedule and so forth, there  
25 are only so many hours in our 12-hour days. And so  
26 some of the additional research that people wanted  
27 may or may not be feasible, but we will give it our  
28 best shot with the capable people that we have. And

1 so we'll try to bring the papers back the next time  
2 for those.

3 Yes, Peter.

4 MR. LEE: I would appreciate it at the  
5 next meeting -- given how long it took us to go  
6 through risk adjustment, which in some ways was a  
7 relatively easy one and it took, I think, about two  
8 hours to go through, what would -- I would certainly  
9 like what's the best or worst case in terms of how  
10 many meetings might we actually have or what are we  
11 going to do because I don't feel comfortable saying  
12 we're going to say we're done with discussion on that  
13 and we're going to vote.

14 At the same time, I want to see how bad  
15 can it get. So I would appreciate at the next  
16 meeting if we have two hours per ERG, what does that  
17 mean? And then we are all as Task Force members  
18 aware of what do we try to focus on and recognize the  
19 cost we will incur if we go over two hours or the  
20 state will in theory by not getting a thoughtful  
21 recommendations.

22 CHAIRMAN ENTHOVEN: All right. We'll  
23 try to do that. I think what I'm presently thinking  
24 but, of course, I'll confer with Phil, Alice and  
25 Hattie, Sara, et al, is that it's almost a foregone  
26 conclusion in our mind that we're going to have both  
27 of those two extra meetings, but I'm not even going  
28 to say it.

1 Well, we might. Let's see. We'll take  
2 a look at that and review our experience so far and  
3 see how it goes.

4 If people want to set up camp in  
5 Sacramento the week of December 15th and work through  
6 the rest of the -- the only problem --

7 MS. BOWNE: You know, Alain, we had a  
8 really good discussion on risk adjustment and I think  
9 we learned from one another, and hopefully we don't  
10 have to rehash all of that again.

11 CHAIRMAN ENTHOVEN: I'm expecting with  
12 risk adjustment that I'll make the changes that we're  
13 suggested and we might be able to march through that  
14 one in 15 minutes or I would like to hope so.

15 We'll see.

16 MS. DECKER: Remember there are going  
17 to be other people at that meeting, a different set  
18 of the Task Force.

19 CHAIRMAN ENTHOVEN: Well, I just don't  
20 know what to do about that. I mean, what is your  
21 sense? Do you have some different idea?

22 MS. DECKER: No. I just --

23 CHAIRMAN ENTHOVEN: I have a problem  
24 with the idea saying, well, we will just, you know,  
25 move to Sacramento starting December 15. Any  
26 problems with that is the fogs and so forth, but one  
27 of them is that we need time between meetings to do  
28 all this recycling.

1 DR. ROMERO: I think this is a  
2 reasonable timing, but I think that it's going to --  
3 I think that the next big --

4 MS. BOWNE: It's going to require  
5 discipline.

6 CHAIRMAN ENTHOVEN: I think part of the  
7 discipline that's going to be required is people are  
8 really going to have to prioritize and their comments  
9 and their demands for rewrites of the paper. I think  
10 people need to really try to pinpoint the -- pinpoint  
11 the points that they think are really important and  
12 just hope to get those in through the revised paper.  
13 We're not going to be able to rewrite every paper to  
14 everybody's satisfaction, obviously.

15 MR. LEE: Just one suggestion, many  
16 issues that we can have in a one hour discussion on  
17 the 28th would be helpful because of staff has the  
18 wonderful luxury of having almost a longer window  
19 between then and the next meeting.

20 So it might be recommended a two hour  
21 discussion if we have a somewhat shorter working time  
22 to do redrafts and staff's consideration for  
23 scheduling.

24 DR. ROMERO: You're saying schedule  
25 less time per paper?

26 MR. LEE: It might be helpful to have  
27 more topics discussed because hitting on the major  
28 issues they can staff more time to rework and come

1 back when we have two meetings in a row the next  
2 time.

3 DR. ROMERO: Since we're on the  
4 subject, I would like to, I guess I would like to  
5 invite your or anybody else's reaction to a  
6 procedural question I've got.

7 Okay, say October 28th we have specific  
8 papers which are going to be up for vote. People  
9 have, let's say for the moment, a given member, you  
10 know, has no real substantive disagreement with it  
11 but has wordsmith quibbles. Are the members prepared  
12 to vote, in essence, conditionally, you know, vote  
13 subject to direction of the staff, you've got to fix  
14 these wordsmith. That's obviously my preference,  
15 yes.

16 MS. O'SULLIVAN: Before I think you  
17 said 10 days before, now you pensioned a week and it  
18 just it really is difficult because it's not just  
19 people at the table, it's organizations that just to  
20 encourage that.

21 DR. ROMERO: Our target is 10 days.

22 MS. O'SULLIVAN: I understand, but it's  
23 I just don't want to have us come in and say we can't  
24 vote.

25 MS. SINGH: You'll always have at least  
26 seven days.

27 CHAIRMAN ENTHOVEN: We're going to  
28 conclude with comments from Barbara Smith, RN.

1                   MR. RODGERS: Just a question, when we  
2   vote are we voting on recommendations or are we  
3   voting on the whole paper because I would rather just  
4   vote on recommends and just wordsmith the background  
5   and all that. I think if we could focus on that, it  
6   would expedite things.

7                   DR. ROMERO: distinguish the background  
8   papers from more the policy, I think, with the  
9   background papers.

10                  CHAIRMAN ENTHOVEN: We need to approve  
11   or not approve the paper, the Task Force, you know,  
12   considers this its work product, okay, with the other  
13   ones. I think that would be wonderful if we could  
14   just argue it out on the recommendations and not try  
15   to rewrite the papers.

16                  MR. RODGERS: I agree.

17                  CHAIRMAN ENTHOVEN: Let's think about  
18   that. If that was widely acceptable that would be  
19   great.

20                  DR. ROMERO: That would be my  
21   recommendation.

22                  CHAIRMAN ENTHOVEN: Barbara Smith.

23                  MS. SMITH: I didn't come here to speak  
24   today, I came here to learn and listen, but the staff  
25   had encouraged me to get up and say a few words.

26                  I am the chairperson of the Orange  
27   County Managed Care Task Force. I'm also a  
28   registered nurse and a consultant in nursing and

1 managed care. We started this task force in June and  
2 I would just like to give the Task Force a brief  
3 summary of who we are, what some of our concerns are,  
4 and also we would like to publicly thank Dr. Phil  
5 Romero for having a conference call with us, our task  
6 force, about a month ago on issues of the vulnerable  
7 elderly in Orange County.

8                   How we got started, we are a group of  
9 concerned health care providers. The question came  
10 up are you bipartisan, indeed we are. We're simply  
11 Orange County administrators, doctors, nurses, folks  
12 that work in residential care, subacute and acute  
13 care that had one of our monthly meetings in June.  
14 And we had many issues all along for a year on  
15 managed care, so we said let's invite representatives  
16 from some managed care entities to come and speak  
17 with us.

18                   We had a breakfast meeting with about  
19 75 members of our group and we invited PacifiCare,  
20 Talbert Medical Management and Kaiser Permanente who  
21 were very nice to come and speak with us.

22                   It was a very wide clear gap between  
23 where the rubber hits the road and presenters  
24 concepts and theory, in other words what was observed  
25 in the crowd was what experienced clinically at the  
26 operational or the trench level with the vulnerable  
27 elderly population was not what we were hearing in  
28 terms of the theoretical health plans.

1                   And there was also we noticed a  
2 knowledge gap in terms of one of the members was not  
3 familiar with what residential care was and the very  
4 common issues with the care of the elderly.

5                   So we decide at that point to go to our  
6 President Dr. Diane Dunn and who said maybe what we  
7 need to do is form a managed care task force and  
8 constructively see how can we improve the care of  
9 this vulnerable population.

10                  In order to put together a mission  
11 statement we referred to --

12                  CHAIRMAN ENTHOVEN: I'm worried that  
13 you're not on a track that's going to get this  
14 finished in three minutes so could you get to the  
15 recommendations and conclusions, please. I'm really  
16 awfully sorry to do that, I apologize.

17                  MR. LEE: The staff is great about  
18 circulating copies of overheads to everyone. If you  
19 give that to staff, all the members of the Task Force  
20 will get that.

21                  MS. SMITH: Basically I just want to  
22 make it clear that our mission came out of the  
23 commission out of Washington, D.C. And their report  
24 on the vulnerable elderly.

25                  One of the recommendations that we  
26 would like to make is to take a serious look at  
27 problematic cases in the implementation of case  
28 management, particularly the use of the R.N. case

1 manager with the vulnerable elderly population and  
2 clinical supervision and ongoing assessment and  
3 monitoring of these cases.

4 We also would like to have the risk  
5 adjustment certainly considered for this group or  
6 possibly outliers. Thank you very much.

7 CHAIRMAN ENTHOVEN: Thank you.  
8 Finally, Ms. Patti Strong, Services Center for  
9 Independent Living.

10 MS. STRONG: Thank you for this  
11 opportunity to testify and I thank all of you Task  
12 Force members for doing what you're doing.

13 At the very end of this very long day I  
14 want to address an issue that may perhaps be falling  
15 through the cracks. I don't think there's an expert  
16 resource group addressing this issue. At the end of  
17 this long day I want to talk about a long-term view.

18 We're all concerned with the issues of  
19 quality, access and cost, and I'd like to tease you  
20 into thinking about whether or not some of the  
21 treatment options and length of treatments are  
22 sufficient to be both quality and truly accessible  
23 for people.

24 What if you were a 40 year old who had  
25 a stroke and you lost your ability to speak and you  
26 were told that with just four months of speech  
27 therapy you had an 80 percent chance of regaining  
28 your ability to speak but that your provider, your

1 managed care provider would only give you four days  
2 of treatment? How would that impact on cost to not  
3 only you, the individual, in terms of lost earnings  
4 and all kinds of ways, perhaps lost relationships,  
5 lost marriage, lost social involvement? What would  
6 it cost the state in terms of lost taxes paid in to,  
7 you know, from someone with a job that lost a job,  
8 but what would it also mean in terms of you using up  
9 your 20 mental health visits, your 40, you can't  
10 speak and you can't regain the ability to speak  
11 because you only have four treatments of speech  
12 therapy. Don't you think that might be very  
13 depressing?

14                   So I just ask all of you because I  
15 don't think there is a portion of your Task Force  
16 dedicated to the long term view, to please think  
17 about the long-term view in terms of interventions  
18 that need to be made and need to be made in a timely  
19 manner because if they aren't given and if they  
20 aren't given now when they're needed, they will  
21 really, in essence, cost the state far more, never  
22 mind the individual, never mind the quality of life  
23 issues, never mind compassion issues, they will cost  
24 the state far more and indeed the insurer far more  
25 probably in acute needs that this person will present  
26 later.

27                   So please think about long-term issues  
28 in this very lengthy afternoon. Thank you.

1                   CHAIRMAN ENTHOVEN: Thank you very  
2 much. I think you raised some very important points  
3 and I've reflected on that a lot. We have heard from  
4 people concerned and upset because their benefits ran  
5 out, let's say they had coverage for 60 days of  
6 rehabilitation therapy and thinking from the point of  
7 view in the controversy over managed care, one way is  
8 to say, well, that's really an employer purchasing  
9 decision, let's say CalPERS employee representatives  
10 decide that's how much we're going to buy. And the  
11 trouble is it does leave some people with serious  
12 long-term problems poorly cared for. But then  
13 there's also a cost issue and it's almost as if we  
14 ought to get back to more traditional idea of  
15 insurance which is the first thing insurance should  
16 do is protect the back end, the very big costs, even  
17 with the expense of having higher co-payments or  
18 something at the front end.

19                  MS. STRONG: Indeed. I'm really  
20 arguing for thinking of cost not only in the short  
21 end, but in the long run for many people.

22                  CHAIRMAN ENTHOVEN: But paying for it  
23 by saying we'll have higher co-payments, not for poor  
24 people but for other people.

25                  MS. STRONG: We don't live in a fairy  
26 tale world. Costs has to be met somehow.

27                  MS. BOWNE: But actually some of those  
28 issues can be addressed both through actual

1 disability insurance which relates to productivity  
2 and, frankly, good case management. And I think what  
3 you're suggesting are to argue for good case  
4 management where you identify the particular  
5 circumstances in a particular case and short and  
6 long-term gains and then can bend the rules, so to  
7 speak, in order to get the right kinds of care  
8 available to the patient.

9                   And I know that -- I know with my own  
10 company both in its long-term care plans and its  
11 disabilities plans, they would look at those kinds of  
12 circumstances if you have that kind of policy.

13                   CHAIRMAN ENTHOVEN: Okay. Thank you  
14 very much.

15                   I think that concludes our business for  
16 today. I want to thank the survivors for hanging in  
17 there and look forward to seeing you early in the  
18 morning on October 28th.

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I, Katherine Gale, CSR 9793, a Certified  
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That said proceeding was taken before me at  
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I further certify that I have no interest in  
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Katherine Gale, CSR #9793